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TRANSACTIONS

One Hundred Fifty-Fourth Annual Meeting

MEDICAL AND CHIRURGICAL FACULTY

of the State of Maryland

1211 Cathedral Street, Baltimore, Maryland

SCIENTIFIC SESSIONS

Tuesday and Wednesday, April 29, and 30, 1952

Part II

Pages 429–481

Scientific Sessions

TOO BIG A JOB FOR ONE YEAR[1]

PAUL B. MAGNUSON, M.D., L.L.D., D.Sc.[2]

When I received your kind invitation to give the annual Trimble lecture, I wrote Dr. Compton that I had several pretty sound medical papers worked up on the causes of pain in the lower back—I've been working in that field for more than 40 years—but that the ladies might be much more interested in some information on the President's Commission on the Health Needs of the Nation. So, in deference to the ladies, I am going to talk about the latter topic.

Last November, without a word of warning I got a call from the White House that the President of the United States wanted to see me. I took the train from Chicago that night, and the next morning met with the President. The President laid the cards right on the table. He said he was deeply concerned with the health of the American people in these trying days of all-out mobilization. He said he had made certain proposals to bring more and better medical care to the people, but these proposals had precipitated an emotional argument which had clouded the issue. The President said he was not necessarily committed to any one plan—if any group could come up with a better series of proposals than the ones he advocated, he would be the first to support them if they would insure better health for all the people.

For that reason, he said, he had decided after long deliberation to set up a Presidential Commission to get at the facts. He offered me the chairmanship, and promised me an absolutely free hand in choosing the members of the Commission.

For the record, I want to say that I had absolutely no interference or pressure in selecting this Commission. All the members were suggested by me to the President after I considered their interests, ability and fair-mindedness. No one in the White House ever raised a question as to whether an appointee was a Democrat or a Republican, or whether he was in favor of the President's plan or not. Maybe I'm prejudiced, but I think this is the best of a long line of Presidential Commissions. It is absolutely free of politics; we have laid down a rule that no one from a Government agency shall be in any policy-making job.

Of course, we have an awfully big job ahead of us. Let me read you just a bit from the Presidential directive.

The Commission has one major objective, the directive reads. "During this crucial period in our country's history, it will make a critical study of our total health requirements, both immediate and long-term, and will recommend courses of action to meet these needs. The Commission is authorized and directed to inquire into and study the following:

(a) The current and prospective supply of physicians, dentists, nurses, hospital administrators and allied professional workers; the adequacy of this supply in terms of the present demands for service; and the ability of educational institutions and other training facilities to provide such additional trained persons as

[1] I. Ridgeway Trimble Lectureship presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Wednesday evening, April 30, 1952, in Osler Hall.

[2] Chairman of the President's Commission on the Health Needs of the Nation, Washington, D. C., and Chicago, Illinois.

may be required to meet prospective requirements.

(b) The present ability of local public health units to meet demands imposed by civil defense requirements and by the needs of the general public during this mobilization period.

(c) The problems created by the shift of thousands of workers to defense production areas requiring the relocation of doctors and other professional personnel and the establishment of additional facilities to meet health needs.

(d) The degree to which existing and planned medical facilities, such as hospitals and clinics, meet present and prospective needs for such facilities.

(e) Current research activities in the field of health and the programs needed to keep pace with new developments.

(f) The effect upon the continued maintenance of a desirable standard of civilian health of the actions taken to meet the long-range requirements of military, civil defense, veterans' and other public service programs for medical personnel and facilities.

(g) The adequacy of private and public programs designed to provide methods of financing medical care.

(h) The extent of Federal, state and local government services in the health field, and the desirable level of expenditures for such purposes taking into consideration other financial obligations of Government and the expenditures for health purposes from private sources."

A mighty large order! When I met with the Commissioners at the first meeting in the middle of January, there was a collective sigh when I read that directive. However, we decided to go around the table and get each other's ideas on how we could tackle the job.

The Chairman led off. I told my fellow members that I had practiced medicine for forty years and still had implicit confidence in the good, common sense of the American people when a straight proposition is put before them and they are given reasons. I said it was our job to put such a sound proposition before the people. We were not promoting anything—we were trying to find out. I said I felt then, as I have felt always, that there is nothing to the practice of medicine except three things: the prevention of disease, the cure of disease, and the returning of the patient to a useful situation in life.

I told the medical members of the Commission that we could not hold to the proposition that there can be no improvement in our profession, because there has been improvement, tremendous improvement, every year. Conditions have changed a great deal since I started practicing medicine, I said, and maybe the medical profession has been guilty of denying the existence of problem areas without looking at the many sides of the question. As long as one person in this country dies needlessly of illness or disease, there is a problem.

Then I turned to the other members of the Commission—outstanding citizens from the ranks of labor, agriculture, education, dentistry, nursing, as well as medicine, and asked them for their views as to the job of this Commission. I wish I had time to quote from all of them, for they together epitomize the free-swinging, democratic spirit of this group. I cannot resist a few selected quotes.

Walter Reuther, who came up from the other side of the tracks to the Presidency of one of the country's largest unions, made this moving statement:

"I have had the opportunity, and it was not one of my own choosing—to be in about five or six different hospitals during the last five or six years. I was at Duke Hospital. They took care of me very well down there. I wish every American could get the kind of medical treatment I got. I think every American is entitled to it.

"If we can forget about the ideological aspects of this controversy and really talk as people, I think we will agree that the doctors of America are just like everybody else. They want to make their contribution at trying to make America a better place for people because really that is

what the whole fight in the world is about. *It is about people.* We want the kind of America where people can have an opportunity to make their contribution without any restrictions on their growth. We want every child to have the right to grow up strong in mind and body no matter what side of the railroad tracks he is born on. I believe we can look at this problem in terms of what are the health needs of America, what are our facilities to meet those needs, how large the deficit is and then sit down and say, 'O.K. This is the problem—how do free people solve that problem?' "

Clarence Poe, editor of "The Progressive Farmer," one of America's great farm journals, had this to say:

"The average man in America today knows now, more vividly than ever before, how valuable modern scientific knowledge has become in protecting the health and the life of his wife, his children and his family, and the determination to have it. It seems to me that the most important job before our Commission is finding some way, some form of insurance or some kind of help by which the poorest people of the country can get proper medical and hospital care. I imagine I speak for the farm folks on that."

And finally, some wise words from a doctor—Russel V. Lee, who has a big group clinic out in Palo Alto, California:

"I hope we will regard this activity primarily as a research product and not bring to it too many preconceived ideas. I have worked on a similar affair in California for a year. At the end of that time, I was impressed with what I didn't know and didn't have the answers for.

"I am certainly not one of those who thinks there is no need for such activities as this. The need for this Commission's work comes curiously enough from the success of medicine and all medical activities. Up until 1910, it was demonstrable that you were just as well off if you had no medical care as far as longevity was concerned, yet every decade since that time there have been enormous advances in medicine until today it is quite likely you are much better off if you have adequate medical care. I think we have available potentially the medical knowledge and resources to make this country a heaven on earth as far as medical conditions are concerned.

"Our principal task is to point out how these resources should be applied to the problem. It is perfectly certain that most of the infectious diseases can be completely eradicated with what we have now. There is no sense in having venereal disease. A year of proper activity would wipe out syphilis and gonorrhea.

"New fields in medicine have developed with great rapidity, but that puts a tremendous obligation upon medicine. And I mean all the ancillary services, too—hospitals, nurses, technicians, etc.—to render what we have available to the public. The public is demanding it. That is something we must realize.

"I think perhaps the ordinary citizen exaggerates in his own mind the miracles that medicine can do, but when the father of a family whose children are ill believes there is available somewhere the medical knowledge and facilities to save the lives or prevent the crippling of his children, he is certainly going to demand that he get it regardless of what his social status is. He may put up with poor housing and a number of other things, but if it is life or death for his family, he will not put up with it."

All right, we have this big job. How are we going about tackling it?

First of all, the Commission has divided its work up into three parts:

1. Assessing the total health resources for the country. A staff of technicians has been working on this since the middle of January—digging into the complexities of number of health personnel, hospital beds, health education facilities, health insurance coverage, costs of medical care, and so on. Sometime in the fall, the Commission hopes to bring out a monumental and important

volume entitled: "The Health Resources of the American People." We think it will be the first completely factual, unbiased analysis of our total health strengths and shortcomings.

2. The second part of the tri-partite working plan, estimating the health needs of the American people, is now keeping us busy day and night. We have scheduled a series of more than 25 panels on every imaginable phase of medical care. Each of these panels is an all-day give-and-take session—no formal testimony and no ceremonial parading of witnesses. The country's ten or twelve top experts in each of the fields sit down for a day behind closed doors and bat the problem around. The panel findings are then digested and presented to the full Commission. By the time of the final panel somewhere around the last week in June, the Commission will have heard several hundred top medical and lay experts from every section of the country give their off-the-cuff views on everything from promotion of health and prevention of disease to care of the mentally ill and the status of rural medicine.

We held seven all-day panels in April, and I attended every one of them. The second week in April, we had separate one-day panels on general practice, specialization and group practice, and I want to say to you without one ounce of exaggeration, they were the finest, most stimulating discussions of the subjects I have heard in 40 years of listening in at medical meetings. No holds were barred. As an example on the second afternoon we had the general practitioners and the specialists come in and have at each other. You should have seen the fur fly.

We have kept up that gruelling pace since then. In the last two weeks of April, we had panels on rehabilitation, regional medical plans, promotion of health and prevention of disease. The stenographic transcript of these April meetings runs to over 2,000 pages, and we have a lot more panels to go.

And that's not all in the health needs area. Prior to these panels, the Commission held a series of formal hearings on aid to medical education and local public health units. We heard 16 experts give fact-packed testimony which filled more than 500 pages of the Commission's official records.

As a final step in estimating health needs, Commission members are now mulling over the idea of a series of field trips to get a close, realistic view of both the good and bad in medical care today. As an example, there is talk of a trip to rural Mississippi to find out just what medical care rural people get. In addition to talking to people on the spot, the Commissioners would visit country practitioners, look over local hospitals, study the state's regional medical plan, and so on. Another trip might take Commissioners to a defense-impacted area where they could observe the many problems created for providers of medical care by sudden shifts of population.

3. Finally, when all the health resources have been inventoried, and all the needs have been ascertained, the Commission will get down to the job of making its formal recommendations to the President trying, as far as possible, to fit its final proposals within the framework of the achievable health resources of the country.

Now I want to talk to you a bit about what is closest to my heart—taking care of sick people and preventing people from dying. In the five years that I was with the Veterans Administration, I had only one paramount concern—getting our veterans well again and returning them to society as useful, productive citizens. I wouldn't give you a million dollars for one inch of red tape in that operation, but I wouldn't take a hundred million dollars for the satisfaction I got in feeling that I helped in a small way to return thousands of veterans to good health.

It is true that we have made great strides in the past half century in the improvement of the general health of the American people. From an

average lifetime of 49 years in 1900, our life expectancy has risen by more than one-third to nearly 68 years at present. This is a singular tribute to the skill and devotion of the American medical profession.

However, as my friend Walter Reuther puts it, there must be no sacred cows in American life. He points out that the workers in his union make good automobiles, but they could make better ones. In like manner, we doctors are providing good medical care, but we could provide better medical care. We are not perfect. Those few in our profession who, ostrich-like, deny the existence of any health problems do their own profession and the American people a great disservice.

Let me give you an example. At one of our Commission meetings, we heard testimony from Dr. Howard A. Rusk who, in addition to being medical director of the Institute of Physical Medicine and Rehabilitation in New York City, is chairman of the Health Resources Office in Washington. The Health Resources Board has been making some intensive studies over the past several years of the total health requirements of the nation. Here are a few of the figures Dr. Rusk gave to the Commissioners:

1. There are estimated to be between 25,000,000 and 28,000,000 handicapped people in this country. This includes between nine and eleven million people with heart disease, probably a third of whom are severely disabled; about six million with arthritis; two and a half million with orthopedic disabilities; 1,500,000 hemiplegics; 600,000 amputees; 50,000 paraplegics, and so on down the line.

Dr. Rusk said a Health Resources task force report on rehabilitation showed conclusively that from two to four million severely disabled people could be gainfully employed if they received adequate training. With a dynamic program, 90 per cent of all severely disabled persons can do some type of gainful work. For example, in a survey of some six hundred paraplegic minors whose paraplegia had existed anywhere from six months to 21 years, 80 per cent were placed back in gainful occupations after an average training time of 4 months.

He told some moving stories—for example, of a boy with both hands off who was suicidal when he entered the New York Rehabilitation Institute. That boy, who has a wife and three children, is now a mechanic's helper at Sperry Gyroscope handling 40-pound boxes.

Dr. Rusk pointed out an amazing thing—out of a thousand people his Institute had trained and placed in industry in the last 18 months, only four had to be replaced.

We had the same experience in the Veterans Administration. In the Minneapolis hospital, we had 169 patients who had been bed-fast anywhere from two to fifteen years. We instituted a rehabilitation program up there with a group of doctors. It takes a group to do it—the orthopedic surgeon, whom I mention first because that is my category, the neurologist, the psychiatrist, the psychologist, the internist, and everyone else they want to call in.

That group went to work on those 169 patients who had been in bed for so long. Inside of nine months, fifty per cent of them were back earning a living. At this time, four years after the program started, only nine of those patients are still bed-fast!

Now, remember this—until this program had started, nobody had paid any attention to them, nobody had given them any help, nobody had guided them, nobody had taught them what they could do toward making a living with what they had left. Sure, it was a tough job. Many of them had arthritis, and I know arthritis hurts, but it doesn't hurt half as much when you're busy as it does when you're just loafing, sitting in bed just thinking about your suffering. Getting these people back to work in itself is enough to give them a new hope, and when it comes to the humanitarian side of it, it is a most important part of medicine.

Dr. Rusk also gave the Commissioners these additional findings from various studies by his

Health Resources office:

2. One out of every 18 persons in the United States is now suffering from some form of mental illness, and one out of every ten persons will need psychiatric care at some time in his life.

3. About 20,000,000 people now alive will die of cancer unless new treatments and cures are found.

4. Two persons out of three in the United States need financial help to meet the costs of serious illness.

5. Sickness absenteeism costs the nation the full time of 2,000,000 workers each year.

6. The nation's medical schools are faced with a serious financial crisis. Their deficits in 1948 totaled $10,000,000 and are running higher today.

7. Nearly 50,000 nurses over and above those now in sight will be required by 1954 to meet both civilian and defense needs.

8. Nearly 30 per cent of our citizens live in communities in which there are no full-time local public health services.

When problems such as these exist, can we say there is no room for improvement? We all know of areas where a better quantity and quality of medical care can be given.

Can we do the job of surveying the health needs of the nation in the brief year allotted to us? I don't think we can do an absolutely comprehensive job, but I think we will come forth with some solid facts and recommendations in December. However, there is feeling among some of the Commissioners that this is really a five-year job which will change from year to year. If this Commission is to be of any permanent value, it should be a continuing Commission on the basis of the interest of the medical profession and the public to put all the information together that we can gather.

We need the cooperation, in our difficult task, of both the medical profession and the general public. As *The New York Times* said recently: "It would be tragic indeed if full cooperation is not given to them (the Commissioners) in their efforts."

I didn't want this job in the first place. I have had my heart set on establishing a physical medicine and rehabilitation institute in Chicago before I retire from practice, and my present duties with the Commission have postponed that work. However, I could not in all conscience refuse the President's call to duty. I suppose I've got a reputation by now as a pretty frank talker, so let me quote to you what I told the press the day I was sworn in on this job; and I now quote:

"I believe that my professional brethren know that I am interested in no way in politics. I took this position, which is an unenviable one, to see if information could be gathered from all sides and all shades of opinion to make a cohesive story so that both the laity and the profession could understand the difficulties and hazards of the distribution of health services to the people of America, and to see if there is any way to improve conditions without interfering with the whole economics and ideals and progress of American medicine. I think it can be of great educational value to the American people to have a Commission discuss these things openly and freely, and without malice."

I have high hopes for this Commission. In the past few years, there has been an excess of emotion and charges and counter-charges about this whole health problem. I agree with *The Washington Post* that, in this bitter dispute, the forgotten man has been the citizen in need of more and better medical care. If this Commission can inject some light where too much heat has prevailed in the past, it will help signalize a desperately needed moving forward in bringing better medical care to all Americans.

Thank you again for the opportunity to share my problems with you.

"Vote As You Please—But Please Vote November 4th."

YOU AND YOUR A. M. A.*

You Are the A. M. A.

WALTER B. MARTIN, M.D.[1]

It is a great pleasure to be here today. This is the place of my medical birth. Forty years ago I came here to begin the study of medicine. It is satisfying to return to old scenes, to greet old friends, and to revive memories of my great teachers. I want to thank you for granting me this pleasure. I am particularly gratified to have a place on your program, and to have the opportunity to talk with you about some of the common problems of your society and the American Medical Association. Medical organizations have their place in society, and these organizations must concern themselves with the economic and social aspects of medicine, as well as with the science and art of medicine.

The science of ecology deals with the effect of environment on an organism. That organism may be an amoeba in its primordial bog, the American buffalo on the western plains, or the body of American medicine. Certainly there are many economic social and political forces that now influenced and will influence the environment of medicine for good or evil. The future quality and quantity of medical care, its availability, and its cost, will be determined by the direction and control of environmental factors. Medicine, to flourish, must have a favorable environment.

Men group themselves together to improve and protect their environment. In so doing they may be motivated by selfish or altruistic purposes. What of medicine? The American Medical Association is the largest and most powerful medical group in the world. Its fundamental policy is expressed in its constitution, and code of ethics. Article Two of its Constitution states that "The objects of the Association are to promote the science and art of medicine and the betterment of public health." Certainly no greater medical objective could be formulated. How well have we accomplished this purpose? How well will we in the future continue to work for the betterment of the health of the public, rather than for selfish ends? This is for you as physicians to decide, for you or the American Medical Association.

The American Medical Association is a federacy of state associations, with no authority to control or direct them. The component county societies are autonomous units and they elect the delegates to your state conventions. The states in turn elect delegates to the House of Delegates of the A. M. A. This House of Delegates is the policy-making body of the A. M. A. It is made up of representatives of the several states and territorial associations, with the addition of one representative from each of the scientific sections, one from each branch of the armed forces, and one from the Veterans Administration. It is truly a representative body that elects its speaker and formulates its own rules of procedure. Any member of the A. M. A. may listen to the proposals and debates in the House of Delegates. All reports and all resolutions introduced into the House are referred to Reference Committees of the House for detailed consideration. Any member of the American Medical Association may appear before any one of these reference committees and present his views for or against the matter under consideration.

* Papers presented on Tuesday morning, April 29, 1952, at the Annual Meeting, Medical and Chirurgical Faculty of Maryland.

[1] Norfolk, Virginia, Member of Board of Trustees of the American Medical Association.

The House of Delegates chooses the elective officers of the Association by secret ballot. The members of the Board of Trustees are elected by the House of Delegates in the same manner. Their total term of office is limited by our Constitution. Of the eleven members of the present Board of Trustees, there are only three who were serving on that body when I became a member less than five years ago. It is sometimes charged that the A. M. A. is controlled by a small group of reactionaries, that it is ruled by a hierarchy. If so, it is a strange one, for it cannot perpetuate itself nor can it exert punitive power over the state or county societies. The state societies elect the delegates who choose the Board of Trustees, and who formulate the policies of the A. M. A. If you are dissatisfied with the policy of the A. M. A., or perhaps its lack of policy, it is possible for you to change that policy, for you are the American Medical Association.

How does it work for the betterment of the health of the public and the advancement of the art and science of medicine? It operates through ten councils, five bureaus, and other special departments. It publishes a weekly Journal, the most widely circulated and I believe, the best medical journal in the world. In addition, it publishes nine special journals of great interest.

Dr. Howard, in his discussion, has outlined for you the organization of the A. M. A. headquarters and has described some of the activities of its several councils and bureaus. They are concerned with improvement in medical education in both the undergraduate and postgraduate field, with the quality of foods, drugs and appliances, with exposure of frauds and protection against industrial hazards, and with extension of medical facilities and medical care.

The A. M. A. is also constantly engaged in careful analysis of proposed legislation, particularly in the Federal field that may affect the future medical welfare of the American people. These are only a part of the activities that Dr. Howard has described to you.

I would like to discuss with you certain of the policies of the A. M. A. You should know what its policies are and why they are being followed. If you believe they are sound, you should support them. If you think they are unsound, you should, through the medium of your local and state society, oppose them. If you have better policies, you should advance and urge them. The one thing you should not do is to ignore them since they are at present your policies.

We are often urged to formulate an overall national plan, a blueprint, if you please, for a system of medicine that would provide for all of our health needs. Such a plan has been proposed by Mr. Truman, and his aides, and presented to the Congress as the Wagner, Murray Dingle Bill. Study that bill carefully, its administrative features and its methods of financing, as well as its declaration of purpose, since it is the pattern of many other bills bearing on medicine. We believe that it is foolish and impractical to attempt to blueprint a system of medicine for this country, with its vast area, varying population density and diversity of social economic and medical needs. Neither the Federal Government nor the A. M. A. is capable of such an endeavor.

It is as foolish as the proposal contained in a bill several times introduced into the Senate, to appropriate one hundred million dollars, and to direct the President to assemble at a suitable place in the United States the outstanding scientists of the world and to direct them to find the cause of cancer. I am sure you believe as I do, that medical progress does not come about in that manner and that the control of cancer will not be accomplished by presidential fiat.

Progress in the social-economic aspect of medicine must come about as in scientific medicine by study, research and experimentation. In this connection one of the most valuable bureaus of the A. M. A. is the Bureau on Medical Economic Research.

To advance, however, we must establish certain principles and state at least tentative objectives. The first of these principles and it is

hardly necessary to state it here in the "Free State," is that governments are justly created by the people and that any bill that undermines or threatens to undermine our constitutional guarantees should be opposed. We must not trade our future security against undue Federal power for a pleasing or laudable immediate accomplishment.

What are our objectives and how do they apply to some of our immediate problems? We desire to continue the improvement in the quality of medicine, and to extend its quantity and distribution. We wish to lower the economic and geographical barrier that separate parts of our population from good medical care. We desire to preserve a sense of the responsibility of the patient for his own health, and the freedom of the physician to practice medicine in accordance with good teaching and sound ethics. It is our purpose to protect the freedom of medical teaching, medical research and medical practice from political control and to stimulate in every way the further advance of the science and art of medicine.

It is not enough to establish principles and objectives; these must be translated into action when particular problems arise.

We have urged the consolidation of the widespread medical activities of the Federal Government, with the exception of the medical service of the Armed Forces and the Veterans Administration. We opposed that portion of the Hoover Report that included these agencies, since we believed that total consolidation would interfere with the primary mission of the medical service of the Armed Forces, and that the inclusion of the Veteran medical service would not accomplish any real economy.

We have urged before the Congress that it define the responsibility of the Federal Government to various groups of its medical beneficiaries. At present the situation is utterly confused. We have repeatedly pressed for a National Hospital Board empowered to pass upon the need for and location of new Federal Hospitals and to allocate beds in existing hospitals according to the needs of the several services. It is in this area that real economy can be accomplished.

We have opposed many bills because of administrative features. While the purposes of many of these bills, as stated in their preamble, have been highly desirable, their method of implementation would be destructive. The general pattern is usually the same, a laudable purpose, a blank check on the Federal Treasury, a Federal Administrator, and state participation on the basis of a state plan acceptable to the administrator. The administrator is granted the power to issue such regulations as *he* deems necessary to carry out the purpose of the act. These regulations unless specifically challenged in Congress, in six months become law. If the state does not bow to the will of the administrator, they are denied access to this particular grant, although they continue to pay their share of taxes into the Federal treasury. In most of these medical welfare bills, access to the courts on equality with the administrator is denied.

We have opposed Federal aid to medical education. The danger of political or ideological control of education is a constant threat to the integrity of a democratic form of government. We do not believe that it is possible to provide Federal aid to medical education on a broad scale so safe-guarded that the integrity of education will not be seriously threatened. We are fully aware of the financial problem of medical schools. Through the National Medical Education Foundation we hope to help resolve some of these difficulties.

I would remind you that none of you here paid the full cost of your medical education, and that your debt is past due. One hundred dollars each year for ten years, from each debtor, would provide abundant funds to meet the present operational needs of the medical schools and would yet repay only a portion of the debt that you owe.

The A. M. A. has consistently urged the ex-

tension of public health service to all of the people. We have not supported plans that would deprive states and localities of proper jurisdiction or that are not consistent with sound economic policy. We insist on a clear definition of the proper scope of medical practice and preventive medicine.

We believe that the American people are capable of protecting themselves against the catastrophic hazards of illness by voluntary insurance just as they protect themselves against other economic hazards by life, fire and automobile insurance. Through the Council on Medical Service every aid is extended in promoting voluntary plans. Already two-thirds of our population are covered by some form of protection in the health field. Maximal coverage can only be accomplished by more intense interest and activity on the local level.

Time does not permit a review of our policies in all of the fields of medical endeavor. I would point out that we are deeply concerned with the whole problem of Federal subsidies and grants-in-aid not only in the medical welfare fields, but in all fields. The burden of Federal taxation is becoming insupportable. Local sources of revenue either by gifts or taxation are drying up. The deadly cycle of taxation, Federal subsidy, higher taxation and increased Federal power, even now threatens to undermine our form of government and destroy our freedom.

Only by revival of a sense of local responsibility and an insistence on maintenance of local control can the drift to Federal dominance be checked. Your local societies and your state societies have a great responsibility in aiding in the cure of ills of the medical body politic. You can also exert your power and influence through the A. M. A. If its policies do not meet with your approval, you have the power to change them, for *you are* the American Medical Association.

The Structure and Functions of the American Medical Association

ERNEST B. HOWARD, M.D.*

MR. CHAIRMAN, LADIES AND GENTLEMEN:

The American Medical Association is housed in Chicago in a nine story structure occupying a large portion of an entire city block. Included within the building is a complete printing plant occupying the first three floors, and the offices and staff of the many different Councils, Committees, Bureaus and Departments that serve the Association. (Fig. 1.)

More than 136,000 physicians are now members of the Association. Their membership is dependent upon membership in 1,987 component county medical societies and 53 constituent state and territorial medical associations. (Fig. 2.)

The component county medical societies constitute the basic structural unit of the Association. Each component society selects representatives to the state society who, in their turn, select representatives to the House of Delegates of the American Medical Association. These delegates are selected on the basis of one per thousand, or fraction thereof, American Medical Association members in each state society.

The House of Delegates is the policy making body of the Association and conducts its business at two sessions held each year. It elects a Board

* Assistant Secretary of the American Medical Association.

of Trustees of nine, and a President and President-Elect who also serve on the Board. During the interim between meetings of the House of Delegates the Board of Trustees conducts the affairs of the Association but all matters of policy established by the Board are referred to the House of Delegates for final approval or disapproval. Thus, the American Medical Association is a democratic organization based on representation of its members from the county through the state to the national organization.

In addition to the Board of Trustees the House of Delegates elects members for its "Standing Committees." (Fig. 3.) These committees include the Judicial Council, Council on Medical Service, Council on Medical Education and Hospitals, Council on Scientific Assembly and Council on Constitution and By-Laws.

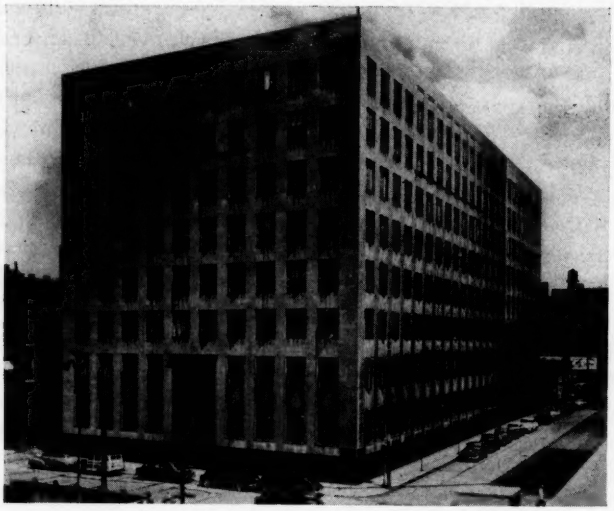

FIG. 1. American Medical Association building (9 story), 535 North Dearborn Street, Chicago, Ill.

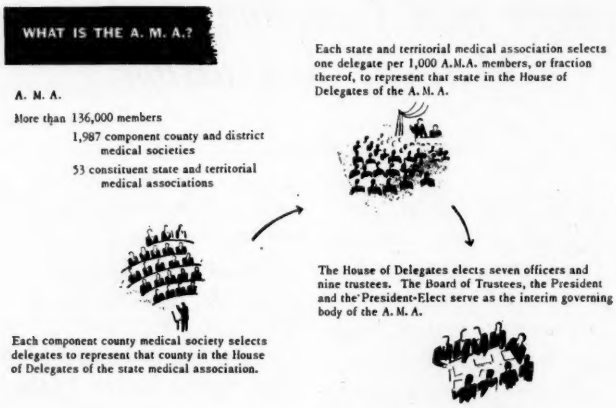

FIG. 2. What is the A. M. A.?

The Judicial Council is the "Supreme Court" of the Association. It adjudicates controversies in all questions involving the Constitution and By-Laws, principles of medical ethics to which the American Medical Association is a party, controversies between two or more constituent associations or their members, and it has original jurisdiction in various other matters. In addition, it serves as the last Court of Appeal for problems arising within the component and con-

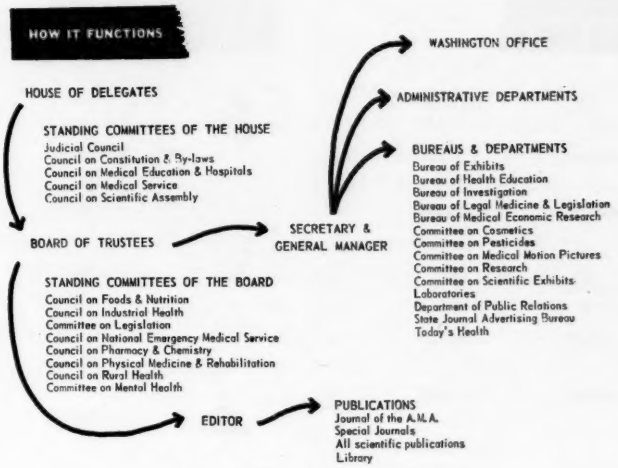

FIG. 3. How it functions

stituent associations. In considering questions as an Appellate Court it considers only questions of procedure, not of fact.

The Council on Medical Education and Hospitals is one of the older Councils of the Association. To it is due much of the responsibility for the vast improvement that has occurred in medicine in this country since 1910. Today seventy-nine medical schools—all of the existing medical schools—are approved by the Association and are providing medical instruction second to none in the world. This situation is the result of a vigorous program of inspection of schools, publication of informative material, careful guidance and persuasion, and the dedicated services of the members of the Council on Medical Education. Today a large staff provides inspection service for internship and residency, medical schools and many other services concerned with the Council's program.

The Council on Medical Service is conducting essential research in this broad field. Committees on Federal Medical Service, Prepayment Hospital and Medical Service, Maternal and Child Care, Hospital and Physician Relationship, Indigent Medical Care and Medical Care in Industry are making continuous studies in these important fields.

The Councils on Constitution and By-Laws and Scientific Assembly are concerned with amendments to the Constitution and preparation of the scientific programs respectively.

The Board of Trustees, like the House of Delegates, also carries on its operational responsibilities through the appointment of committees and councils. The Committee on Legislation for example, studies all new federal bills and recommends suitable action to the Board of Trustees.

The Council on Rural Health has established close relationship with various farm groups, particularly the American Farm Bureau Federa-

tion and the National Grange, so that joint planning for medical care in rural areas can be developed. It is through the program of this Council that the doctor-farmer team has been more effectively used than ever before to improve medical service in rural areas.

A new committee on Mental Health has recently been appointed by the Board of Trustees to utilize the resources of the Association with respect to this enormous and important field.

The Bureau of Medical Economic Research has conducted numerous fundamental studies in this field and soon will publish a monumental study on medical service areas. The work of its Director, Frank G. Dickinson, has received wide acclaim.

The Bureau of Health Education headed by Dr. W. W. Bauer, one of the nation's top authorities in this field, is outstanding. Its publications in the field of health, its radio and tele-

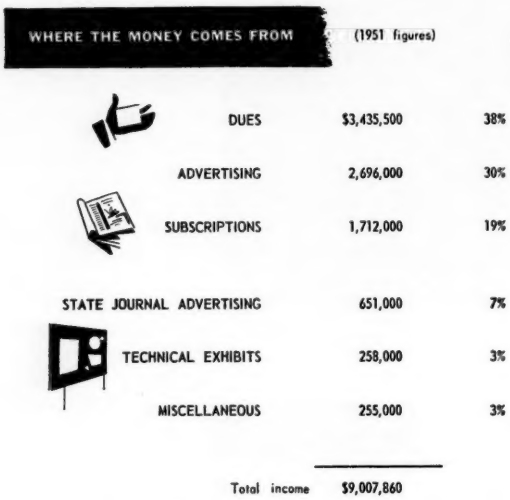

FIG. 4. Where the money comes from

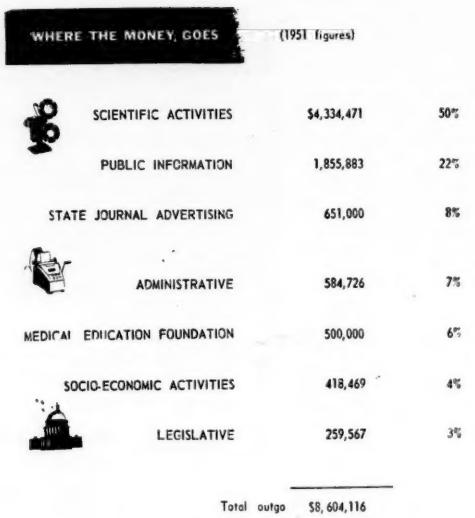

FIG. 5. Where the money goes

The Washington office maintains close relationship with Congress. It supplies information to Congressmen, Senators and many Washington agencies and keeps the Board of Trustees and the Chicago office informed of developments as they occur in the Congress.

Many bureaus and departments as outlined in Fig. 3 carry on important functions but time will allow only brief mention of a few.

The Committee on Medical Motion Pictures has the largest file of medical motion pictures in the world. It has established a joint program with various government agencies to more effectively service foreign nations who are particularly eager to receive medical information from this country.

vision programs, its joint programs with the National Education Association in the field of school health and many others, have contributed significantly to the nation's health.

The Department of Public Relations is relatively new. For some strange reason the American Medical Association has been immoderately modest and has failed to tell the American people and the medical profession of its tremendous service to the public. Pamphlets will soon be completed and distributed to the profession and the public telling them what the American Medical Association is and what it does. Many other pamphlets are in preparation—one on medical cost and another on public relations for

doctors' secretaries. They will add immeasurably to the Association's stature especially in relationship to the public. The other bureaus and departments of the Association all deserve mention and a description of their activities, but time does not permit. They, too, provide essential services that contribute to medical science and public health.

The scientific publications of the Association are, of course, well known to you. The Journal is the top medical publication in the world, and nine special scientific Journals are also top publications in their respective fields. In addition to the scientific journals the Association publishes a Quarterly Cumulative Index Medicus, the Standard Nomenclature and the Medical Directory.

Where does the money come from to finance these many activities? Fig. 4 shows the sources of income of the Association for 1951. It is noteworthy that prior to 1950 when dues were levied on American Medical Association members for the first time, the Association had to depend primarily on advertising revenues for its activities.

Fig. 5 indicates "Where the Money Goes." It should be noted that fifty per cent of the total budget for the year 1951 was expended for scientific activities. Twenty-two per cent was allocated for public information, a portion of which was directed against the present administration's campaign to promote the passage of a compulsory health insurance bill and other legislation designed to achieve the socialization of medicine. Many members will be surprised at the expenditures and receipts of the American Medical Association. It is a reflection of the Association's size and the great variety of its services.

The American Medical Association is the largest organization of physicians in the world, devoting itself to services to the profession and to the public. It deserves the strong support of every one of its members for, without that support, it cannot function effectively. In turn the officers and staff of the Association will continue to provide the information and assistance directly and indirectly to every member of the Association that has made it possible for the practice of medicine in the United States to be conducted on so high a level.

*Remarks of George H. Yeager, M.D.**

DR. GEORGE YEAGER: In the past, State Medical Societies have had a close working relationship with the American Medical Association without any type of financial obligation. The State Society in no way contributed toward the support of the A. M. A. I'm sure that many of you had the personal experience of going to an A. M. A. Convention on the assumption that your State membership card entitled you to all of the facilities and courtesy of an American Medical Association membership. Then you found that you were not entitled to attend the exhibits and certain facilities at the convention, although you were classified as a member of the American Medical Association. You were required, if you were interested in participating in these affairs, to subscribe to a fellowship, as it was called in those days, which entitled you to the A. M. A. Journal.

In the past few years we have placed ourselves on a sound, financial relationship with the A. M. A. I hope personally that when the hue and cry of "socialism" and fear of the Government taking over our profession has quieted down to some extent, even though the financial pressures may diminish on the major association, that we will still have some type of dues payment and that the dues payment will

* Secretary, Medical and Chirurgical Faculty.

continue to entitle us to the journal of the A. M. A.

I don't know whether Dr. Martin and Dr. Howard are acquainted with the confusion that was created in most State Medical Association offices over the changing status of dues and fellowship during the past four or five years. I know that our offices were swamped with continuing complaints, continuing inquiries from the various members as to what was interpreted as a voluntary contribution; an assessment and separation of dues from fellowship. Finally a firm basis of paying your dues to the A. M. A. has been established. You are entitled to the journal and the term Fellowship has been eliminated.

I would go further. The relationships of the A. M. A. from our viewpoint have been entirely satisfactory. Certainly those of us who are connected officially with the State Society are amazed at the ramifications and extensive activities of the A. M. A. I would like to throw this out as a possible suggestion. I do think that the A. M. A. still needs to strengthen its relationship with the average doctor in the average community. Personally, I am embarrassed from the State level viewpoint at the number of our members who do not pay A. M. A. membership dues. I believe that Maryland compares favorably with most States. However, there are quite a few members of the State Society entirely reluctant or unwilling to take the additional step of paying dues to the American Medical Association and becoming a member of the major organization.

I have wondered personally if the A. M. A. couldn't strengthen its position by having some type of regional meetings from time to time, similar to the American College meetings. The A. M. A., as it is now constituted has two major meetings a year, the semiannual and annual meeting, and certainly from the meeting viewpoint they are everything that could be desired. Nevertheless, I believe that most of us who have attended the College Regional meetings have been impressed by their effective programs; by the scientific content and the fact that from the regional viewpoint the average doctor seems to take a much more intensified interest.

I rather believe the A. M. A. might at least think of it from an experimental viewpoint and try one or two regional meetings to see if their relationships with the average doctor are not tremendously improved. Thank you.

QUESTIONS AND ANSWERS

DR. CHESNEY: There is time for a few questions from the floor. Because of my difficulty in hearing, I am going to ask Dr. Yeager to take over the business of hearing the questions and interpreting them through the other speakers.

DR. YEAGER: I don't believe you have been handed slips of papers but if any of you would care to ask questions, I will be glad to transmit them to either one of the designated speakers.

Q.: I'd like to ask if the Panel thinks it is the thing for a member of one of the component County Societies or State Society to hold office in either one of those organizations, who refuses to pay dues to the American Medical Association.

DR. WALTER B. MARTIN: I think that is a problem of local determination. I might express my opinion on it as an individual. I pointed out in what I said to you that the A. M. A., has no punitive power over the State and County Societies. Obviously a man that you're going to elevate to office in your County or State Society ought to have a very broad outlook on medicine, much broader than just his local interest, and he ought to be anxious to participate in the affairs of medicine in this country through the

influence of his State or County Society on the National level. Now, we have no way to enforce such a requirement but I think each County Medical Society and each State Medical Society ought to take action in that respect and the action should be "NO."

DR. YEAGER: I might amplify that slightly. Again I would like to emphasize that the American Medical Association has not imposed any rules or regulations upon a State Society. They have left to the discretion of the State organization ways and means and manner of running their own organization. I think that is truly a democratic system. I wonder whether the A. M. A. might not at least develop some type of principle of guidance for the State Societies, at least to use for what it is worth. From the State level viewpoint I might add that no one other than a fully paid active member may hold any type of position in the State Society. Associate membership does not entitle him to hold office. Are there any other questions?

Q.: Every one of us have been receiving a certain amount of literature and the Medical Association goes to considerable expense in printing this literature and has asked us to distribute it in the office. Some we pay for and some we get gratis. Of course, before we can sell our profession to the public we must first sell it to ourselves. I think that the service of medicine is hardly a personal one of the doctors attending. We must have faith in the organization, faith in the American Medical Association that attends to certain things that we personally cannot attend to. Of course, even the Board of Trustees and the Members of the House of Delegates are practitioners just the same as every individual physician. The American Medical Association ought to impress us that it is largely a personal matter. If, in my office, I take three minutes to explain to a patient what the Government finds new and the reason that I oppose it myself, it seems to me that that sort of teaching of the public is worthwhile and worth a whole lot more than if I take a pack of pamphlets and put in my office with a sign, "Please take one of these home." It is a form of advertising. I think the advertising that we can do is only by our individual word. If the patient is impressed with his own physician's point of view, he goes out and tells his friends what the doctor told him.

Our profession has not been one of advertising. It ought to be very carefully watched. That is the thing to think about. A physician ought to have complete confidence in the American Medical Association. It is much easier for me to take a bunch of pamphlets and put them in my office and let the patient take one than it is for me to take a minute or two in the office and tell the patient what we are up against and how we oppose it and why we oppose it.

DR. YEAGER: I'll have to make one comment and pass that on. I believe all of us are totally agreed with your theory, but unfortunately in practice—and I see Dr. Goldstein and Dr. Koontz, Dr. Finney, Dr. McLanahan in the audience and various people that have been interested in some of these problems. I think they will all confirm the statement that the average doctor is totally unwilling to take the time to discuss these problems with their patients or even with their confreres. They, for some reason or other feel that someone else should do the job for them. I have discussed it repeatedly with friends of mine and they make the rather inane plea that they want to be left alone, that they only want to practice medicine. After all, that is the philosophy that all of us are directing our efforts toward. If we can overcome this immediate crisis and pressure that has been placed upon us, we can devote our full energies to the practice of medicine. You will find in dealing with the great majority of doctors that they are totally unwilling to make any personal effort on any of these problems. Would you care to amplify on that, Dr. Martin?

DR. MARTIN: Only in one respect. We found an enormous number of doctors who are not familiar with the facts, consequently they

couldn't transmit information to their patients until they were informed themselves. The purpose of the facts are two-fold and I think your suggestion is absolutely sound. One is to give the individual doctor access to basic information and then he could discuss those matters with the patient and friends—"Now here is something on that, if you're interested," and give him a pamphlet. It was never intended that they were put on the office desk and just shoveled out to the patients in the hope that a little seed would sprout from one of them.

DR. YEAGER: Any other questions?

Q.: I'd like to ask Dr. Howard if the A. M. A. still publishes a small pamphlet on medical ethics?

DR. HOWARD: We publish "The Principles of Medical Ethics."

Q.: Do you have to pay for that or would that be supplied to the County Medical Society?

DR. HOWARD: It varies, that depends on the quantities you want. We usually distribute quantities up to fifty free. Beyond that we may or may not. It depends on the size of the quantity requested.

Q.: I had in mind supplying a new man coming into the County Medical Society with a copy of the Medical Ethics.

DR. HOWARD: I think that is a good policy. Incidentally, we are preparing a new pamphlet for the public that will also be useful for physicians. It will be entitled "The Code Your Doctor Lives By," which will be distributed widely to the public and which will demonstrate to them the kind of ethics the profession requires. I think that is a very good suggestion that all new members certainly should read the Principles and have it with them.

STATEMENT FROM THE FLOOR: Mr. Chairman, I might say the A. M. A. gave a few hundred copies of the Medical Ethics to the Baltimore County Medical Association and we gave a copy to every member and also sent an abstract of the release on public relationship. That also was distributed free to every member of the Baltimore County.

DR. YEAGER: I believe the first pamphlet was recently revised and distributed on Medical Ethics. Is there another question? If not, I'll turn the meeting back to Dr. Chesney.

DR. CHESNEY: I'm sure you all join with me in thanking the members of the Panel for coming here to present this very interesting material. I declare this meeting adjourned and call attention that the Scientific Session will be resumed at two-thirty this afternoon in this hall.

BALTIMORE CITY MEDICAL SOCIETY

Osler Hall
1211 Cathedral Street, Baltimore 1, Maryland

Friday, October 17, 1952, 8:30 p.m.

The Baltimore City Medical Society is fortunate in that the Maryland Heart Association has succeeded in arranging for Dr. Dwight E. Harken, of Boston, Massachusetts, and Dr. Colin M. MacLeod, of New York City, to be the speakers at the opening of the Fall series of meetings.

Dr. Harken will discuss "Surgery of Mitral Stenosis" and Dr. MacLeod will discuss "Prevention and Treatment of Rheumatic Fever."

Scientific Papers

THE LOWER MIDLINE INCISION

CHARLES B. MAREK, M.D. AND JOSEPH R. DOLCE, M.D.*

Baltimore, Md.

The lower midline incision is perhaps used more frequently by the gynecologist than any other, since it has the widest range of usefulness. Yet, in spite of its universal employment, actually there are relatively few who utilize its advantages at all times and to its fullest extent. Very frequently, although beginning initially as a midline skin incision, the end result terminates in a paramedian incision which splits one or the other rectus muscle. The surgeon who cuts directly through the muscle or separates the fibres deliberately, does so either because he feels there is a lessened hazard of a resulting hernia, or because on failing to find the line of separation when first incising the fascia, he will not trouble to seek for it further. On the other hand, those who do seem to take pains to seek the midline, then proceed to open the peritoneum to one side and enter the abdominal cavity without incising the inter-rectal sheath, exposing the opposite muscle or mobilizing the peritoneum, thus declining to exploit the incision to its fullest extent.

With regard to the fear of a subsequent hernia, we do not think this need be considered, as hernias have occurred about equally after both methods. And we are further of the opinion that there are distinct disadvantages in cutting through the muscle, since not only is there apt to be a great deal of troublesome bleeding from the torn vessels, but also the incision severs the nerves resulting in a weakened muscle. Moreover, the incision cannot be satisfactorily retracted, greater force being necessary to separate the muscle in its abnormal line of cleavage, while the complaint of pain in the abdominal wound during the first few days after the operation is more marked. Vertical section through the midline has the advantage of being almost bloodless, cutting no fibres, injuring no nerves, and giving access to both sides of the abdomen.

By referring to any textbook on gynecology, one can readily learn certain fundamental facts relative to the lower midline incision which are both pertinent and highly significant. It should be borne in mind, however, that it is essential for these texts to cover a multitude of subjects, and while the descriptions must of necessity be concise and limited, they are frequently wholly inadequate in their discourse. The surgeon may conceivably also be confused by the descriptions of the rectus sheath in the standard textbooks of anatomy which are singularly alike, being stereotyped and oversimplified. Without exception, it is stated that in the region superior to the level of the linea semicircularis, the internal oblique aponeurosis divides into two lamellae, one blending with the external oblique aponeurosis as it passes in front of the rectus muscle, the other fusing with the aponeurosis of the transversus as it passes behind the muscle; it is further stated that in the territory situated inferior to the level of the semicircularis, the aponeurosis of the three muscles join while coursing across the front of the rectus, leaving the latter's posterior surface in direct contact with the transversalis fascia. The diagrams so illustrated in these books depict this transversalis fascia as continuing from one side across to

* Resident in Surgery, Bon Secours Hospital.

the other without interruption. As a matter of fact, however, each side terminates in the midline where after fusing to form the inter-rectal sheath, the fascia inserts into the linea alba. Yet, in but few articles in the anatomical literature have the conventional statements regarding the constitution of the sheath been either questioned or refuted. Walmsey and Chouke both recognized variations in the constitution of the sheath. Anson and McVay even go so far as to state that the rectus muscle inferior to the linea semicircularis does not lie upon the transversalis fascia proper, but upon a leaf derived from the main layer which splits to invest the muscle and then continues to the linea alba.

To further emphasize the great discrepancy in the description of the rectus sheath, we carefully noted the presence or absence of the pyramidalis muscle in a large number of laparotomies. Chouke claims the pyramidalis was found to be absent in over 22%, while Piersol stated it could not be found in 16%, and Gray mentions merely that it may be absent on one or both sides. However, our experience does not substantiate these findings. Careful observation during over three hundred operations disclosed an absence of the muscle in only 7% of the cases. It would be difficult indeed to explain this wide variance, but the large amount of material may prove to be the important factor, while the sex may also have some bearing on the results. In Chouke's series of 136 cadavers, only 20 were females, while our report is based entirely on female patients.

After reading the average text, one would surmise that it is necessary simply to incise vertically along the linea alba and both recti muscles will fall into view in the lower portion of the incision. But, this is not the case, since it is usually necessary to dissect out the opposite rectus muscle by cutting through the inter-rectal fascial sheath as explained in detail somewhat later. It is also noteworthy that an extensive search of the literature of the past twenty-five years failed to reveal any single article devoted to the midline incision, per se, save for those mentioned previously in textbooks, and since these reports are not too informative, the picture remains somewhat obscure. Primarily, because of the confusion which seems to surround the mechanical features pertaining to the technical aspect of the incision, especially in the minds of the tyro, it will be our purpose to make a conscious effort to clear up the maze of uncertainty which usually confronts the novice, by presenting the subject in a detailed manner.

The technique finally adopted is a combination and modification of various steps which have been employed by others, no priority being claimed for any step in this procedure. We believe that it is a sound approach which is associated with less trauma and lends itself to adhering to the fundamental precepts and principles inherent in good surgery. It would seem obvious that this technique offers theoretically, at least, definite advantages and it is our opinion that the reward far exceeds the trouble and the few extra minutes spent in dissecting out the various abdominal layers. We have also been particularly mindful of the fact that nature is an excellent healer and that there are many who feel that a meticulous dissection of the abdominal wall is unnecessary. While this may be true in a small measure and while we do not mean to imply that this is the only satisfactory approach, yet there are few who would dispute the statement that wounds heal better when blood and nerve supply is left unimpaired, the tissues untraumatized, with the layers approximated carefully in an anatomical order.

Consideration must also be given to several fundamental factors which will increase the efficacy of the incision allowing the operator to exploit its full length. Preliminary catheterization of the bladder is an absolute requisite, affording greater exposure and precluding the possibility of bladder injury. Operation in the presence of a distended bladder can readily convert a fairly simple procedure into a rather formidable one, so to speak, besides preventing full utilization of the incision, since the peri-

toneal opening must necessarily be limited by the advancement of the bladder superiorly. Secondly, it is the accepted opinion that extension of the incision inferiorly provides twice as much exposure as a corresponding extension superiorly, or to quote the words of a well known surgeon, "an inch below is worth two inches above." Thirdly, the Trendelenberg position allows the intestines to be displaced toward the upper abdomen, drawing them away from the anterior abdominal wall, this being of inestimable value during the operation. The advantage of this is twofold; the danger of intestinal injury in opening the peritoneum is greatly lessened, and packing of the intestines is rendered much less difficult, inasmuch as the intestines tend to fall away from the area as soon as air enters the peritoneal cavity.

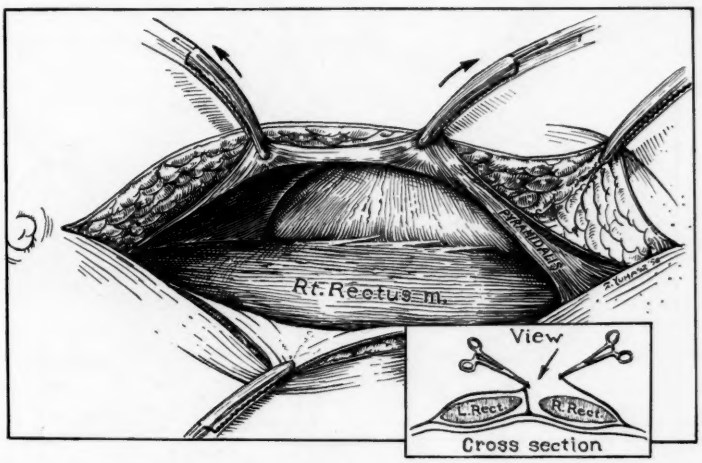

FIG. 1. Schematic drawing depicting the incised rectus sheath with the right rectus and pyramidal muscles exposed. The posterior layer of the rectus sheath is shown inserting medially into the linea alba.

The lower midline incision technic extends from a point 1–2 cms. below the umbilicus to the symphysis pubis. The cut is carried down to the fascia which is freed of the adherent fat for a distance of approximately 1 cm. on each side of the linea alba, being most easily accomplished by holding the knife at a slight angle, while with sweeping strokes, one pushes the fatty tissue aside by sharp dissection. The linea alba is incised preferably slightly to the right of the midline, the curved scissors being used to free the rectus fascia from the underlying muscle, the incision then being extended to its full length superiorly and down to the very surface of the pubic bone. By and large, there should be little difficulty in finding the midline for separation of the recti muscles. If the line of demarcation is not apparent, it will be found that the cut edge of the fascia can be separated from the underlying muscle with the dissecting forceps more easily on one side than on the other, this representing the lateral portion. Likewise, at this point, the pyramidalis muscle in the lower end of the fascial incision is also most useful in directing the surgeon. These arise from the symphysis pubis on a broad base, the outer margin being directed inward and upward, and the two converging into the midline, forming a pyramid. There may be considerable variation in the development of these muscles, some being very prominent and muscular, while others may be somewhat atrophic and fibrous. The medial cut end of the fascia is grasped with two Kelly clamps, placed on tension, and the tendinous

fascicular strands of the inner surface of the rectus muscle which insert into the posterior portion of the linea alba are severed by downward strokes of the knife, held at a slight angle to prevent incision of the fascia.

The muscle can then be separated from the midline with the handle of the scalpel, thus exposing the inter-rectal sheath. This barrier is incised in its lower portion and the incision extended with the curved scissors, being extremely cautious in the superior portion because of the proximity of the peritoneum. At this point, above the semicircular ligament, the inter-rectal sheath is comprised of a substantially thicker, flattened fascial band, so that to all outward appearances, it would seem that the anterior and posterior rectal sheaths had fused along the midline. In this area, also the peritoneum adheres closely to the posterior rectus sheath. At any rate, it is a comparatively simple matter to extricate the opposite rectus muscle, and opening the peritoneum accidently can easily be averted by exercising the normal amount of care. Both muscles are then partially separated from the fascia anteriorly with the handle of the knife, being careful to avoid injury to the perforating branches of the epigastric vessels.

Using the fingers and knife handle for blunt dissection, the left muscle is now separated from the severed inter-rectal sheath, after which, the posterior rectus sheath is freed from the undersurface of the muscles on each side for a distance sufficient to permit the mobilization of this layer and allow its partial delivery to facilitate opening and closing of the peritoneum. The transversalis fascia is grasped with mouse tooth forceps, incised longitudinally, thereby exposing the preperitoneal fat. When this is divided, the peritoneum becomes visible, and usually, the urachus can be seen in the midline. This may be a substantial band and easily demonstrable, as is often the case, but occasionally, it is represented by a thin fibrous cord; in any event, the structure is always present and serves as a useful guide in opening the peritoneum. With considerable circumspection, one proceeds to open the peritoneum, this being done in the upper one-third of the incision to avert damag-

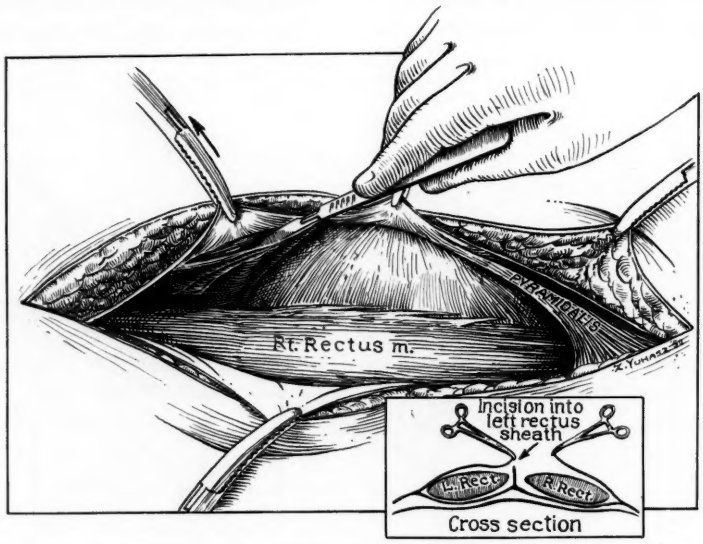

FIG. 2. Schematic drawing showing the incision in the inter-rectal septum opening into the left rectus sheath. The semicircular ligament is shown as the darkened area in the upper third of the incision.

ing the bladder, but at the same time, exercising great caution to avoid injuring the bowel.

The peritoneum is stretched between the forceps, slightly raised, and carefully nicked so that air can enter and displace any intestine or omentum that may be lying in close opposition. After the cut edges are grasped with Kelly clamps, the incision is enlarged by inserting the index and middle fingers of the left hand into the peritoneal cavity, palmer surface upward and with a lifting motion, the peritoneum is divided between the two fingers slightly to one side of the urachus down to the very edge of the bladder. The same fingers of the right hand are used to elevate the peritoneum while extending the incision superiorly with the knife in the left hand. One should not confuse the urachus with the obliterated hypogastric arteries which in the upper portion of the incision are close to the midline. In the main, the latter are smaller in size and diverge laterally from the umbilicus on each side, forming a triangle with the apex upward and coursing inferiorly to the inguinal region thence joining the internal iliac vessels in the pelvis. It need hardly be said that there is little excuse for accidental injury to the bladder, since it may be recognized readily by sensual examination; to wit, by the pyramidal appearance of the area at the junction of the urachus with the bladder, by recognizing the fleshy pink appearance of the muscular fibres of the organ, and by direct visualization facilitated by holding up the peritoneum and looking at it through its inner surface when the limitation of its transparency will indicate the position of the bladder.

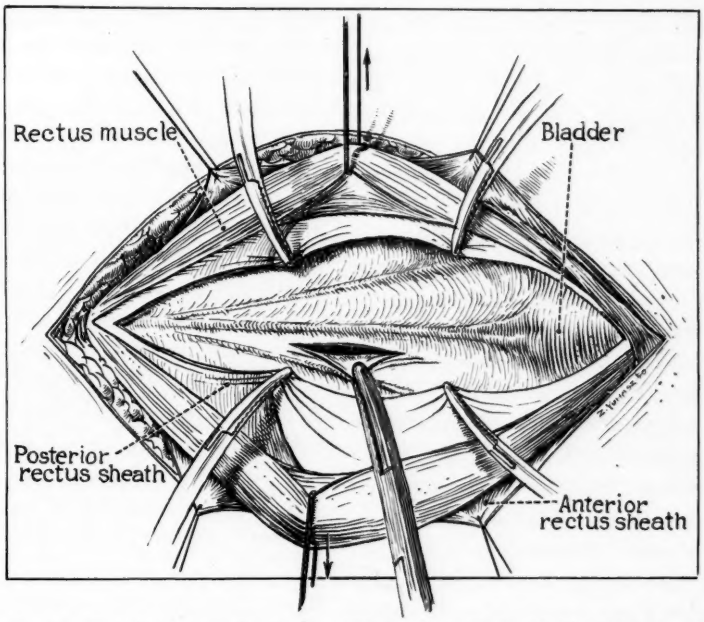

FIG. 3. Schematic drawing disclosing the urachus in the midline fusing with the bladder inferiorly; the obliterated hypogastric arteries are seen on each side of the urachus. The posterior rectus sheath is held laterally with clamps.

Closure of the peritoneum should begin invariably at the superior portion of the wound, since in this area the layers are compact, rather rigid and fixed and difficult to mobilize, while the intestines lie in close proximity, forever presenting a real source of danger. Generally

speaking, it is considered more prudent, therefore, to place the initial suture, under guidance of the fingers, with adequate visualization afforded by the open incision. The continuous stitch should evert the peritoneal edges to render a smooth intra-abdominal suture line, while whenever feasible, the cut edges of the transversalis fascia should be included in the suture. On approaching the inferior portion of the incision, it will be noted that the peritoneum can be lifted easily for a considerable distance through the incision. Furthermore, in this area, the intestine is rarely in close contact since the pelvis is proportionately deeper than the upper abdomen and the intestines fall away from the peritoneum, so one is able to complete the suturing relatively free from apprehension. It is our custom always to approximate the recti muscles with a continuous interlocking suture of plain zero catgut. While there might be some controversy over its necessity, few would persist in the claim, that it does any harm, while in many cases, it perhaps does some good. We feel that it is an added safeguard which may prove beneficial and invaluable in furnishing additional support. The remaining layers of the abdomen are approximated in the usual manner, interrupted figure of eight chromic zero catgut sutures being utilized in the deep fascia, double zero plain in the fat and superficial fascia, while interrupted black silk sutures are used to close the skin. Retention sutures are employed only rarely in extremely fat individuals, since it is our opinion that they serve no useful purpose except perhaps to prevent disruption of the skin in infected wounds.

Conclusions

1. While the lower midline incision is employed extensively by gynecologists, few utilize its full advantages.

2. It is less traumatic, being associated with less bleeding and spares injury to the nerves.

3. Misconception, arising from the equivocal description of the rectus sheath by the standard texts, probably accounts for the existing confusion and the reluctance on the part of some operators, especially the neophyte, to seek the exact midline.

4. An attempt is made to present the opening of the abdomen in a detailed, sequential and anatomical order, with special emphasis on the structure of the rectus sheath and landmarks in finding the midline.

5. Although we should not like to leave the impression that this constitutes the only satisfactory approach to the pelvis, it is our sincere feeling that the method described is superior to the others.

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Reports

COMMITTEE ON RURAL MEDICINE

MEDICAL STUDENT PRECEPTORSHIP

The Committee on Rural Medicine has been studying the problem of placing medical students who have finished their junior year with some rural physician on a preceptorship basis. It is understood that some type of recompense be worked out between the student and the physician.

The legal problems have been ironed out and the physician may use this man under his supervision, or under direct supervision of a licensed physician in case of his absence. Before contacting the members of the present junior class, the Committee on Rural Medicine would like to know how many rural physicians would be interested in having a student during the summer months on a preceptorship basis. The letters must be in before November 1, 1952, and should be addressed to Dr. Page C. Jett, Chairman, Committee on Rural Medicine, Prince Frederick, Maryland.

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ARE YOU INTERESTED?

Veteran-Physicians of World War II

Dr. William T. Spence, Secretary-Treasurer of the Physician-Veterans Society, 1150 Connecticut Avenue, Washington 6, D. C., states that after a survey it was found that 25% of the States would like to have a national Veteran-Physicians Organization.

If you, as a Veteran Physician, are interested in the formation of such an organization, will you indicate your wishes to the Faculty Office, 1211 Cathedral Street, Baltimore 1, Maryland?

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SOCIALISM IS ON THE MOVE

ROBERT W. GARIS, M.D.*

In the concluding remarks of his presidential inaugural address to the American Medical Association on June 10, 1952, Dr. Louis H. Bauer stated "I am proud to be a member of the American Medical Association which has spearheaded the fight against the Socialism that is creeping over this country." That our Governmental course has been proceeding steadily toward State Socialism in recent years is beyond the shadow of argument. Whether we call the present trend Collectivism, Statism, Welfare State, or "Ruinism," as Senator Harry F. Byrd terms it, these new policies of Government, unless quickly checked, will destroy the American system of competitive free enterprise together with our even more important individual freedom and liberty.

The Socialist Party has not campaigned actively in a Presidential election since 1932, and yet today, virtually every plank in that 1932

* Member, Committee on Public Medical Education, Baltimore City Medical Society.

socialistic platform has been enacted into Federal law, and in some cases enlarged upon. Deficit financing, price controls, Governmental housing, Federal water and electric power projects, "full employment" laws, and Federal Aid to education are but a few of the socializing items adopted by the Federal Government—22 such items were recently listed by Earl Browder, former leader of the Communist Party and an authority on Communism and Socialism. Among current socializing projects, as yet lacking enactment into law, are socialized or state medicine, the Brannan Plan—which inevitably means socialized agriculture, and another large extension of socialized housing. These three proposals alone would mean socialization of our health, our food, and the roofs over our heads. Space does not permit citing many other trends to Socialism, such as the constant advocation by the Truman Administration of an extension of the number of those receiving payments from the Treasury of the United States —already 17 million Americans receive regular payments directly from the Federal Government and 8 million more are on the rolls of Counties, Cities and States. A population of government dependents is a socialized population.

Not so well known are two recent Government projects of socialistic nature, which have come to the attention of the Committee of Public Medical Education of the Baltimore City Medical Society. I wish to briefly detail these two proposals.

The first deals with the Niagara Power project. A guest editorial by Dr. John F. Kelley in the Bulletin of the Utica Academy of Medicine summarizes the Niagara question. A 1950 treaty with Canada opened the door for the development of vast new resources of electrical energy at Niagara Falls without interfering with its scenic beauty. Three bills authorizing the project are now before Congress. The private enterprise Capehart-Miller bill would permit the five New York State electric companies to do the job collectively. The other two bills, by Lehman-Roosevelt and Ives-Cole, call for government development and ownership. Never in the last twenty years of encroachment by government on the free initiative of the American people has so clear an issue been presented between government ownership and private enterprise as is embodied in the three proposals to develop additional power from the Niagara River. The Niagara issue is solely one of development of electric power. It does not involve navigation, reclamation, flood control, irrigation, sanitation, or any of the guises previously relied upon by government to go into the electric business. The Niagara project has no connection whatsoever with the controversial St. Lawrence Seaway and power project, which is geographically 250 miles from Niagara Falls.

This clearly defined issue between governmental ownership in direct competition with private enterprise is basic and fundamental, not only to the entire structure of American economy but also to the structure of the private life of individual Americans—and this particularly includes doctors, dentists and nurses because of their deep interest in any matter involving socialization of segments of American life. If government ownership should win out, then a principle or precedent will have been established giving tremendous leverage to future arguments for government ownership. This means another cog in the process of socialization and an alarming outlook for private enterprise.

By letting our representatives in Washington know we favor the private enterprise (Capehart-Miller) bill, we can help check further inroads of socialistic scheming and aid in preserving our American way of life. I may say that our Committee of Public Medical Education by unanimous vote instructed our chairman, Dr. Amos R. Koontz, to write to all Maryland Congressmen urging their support of the Capehart-Miller bill and their opposition to the Lehman-Roosevelt and Ives-Cole bills.

The second piece of proposed legislation upon which our Committee has recently taken action

concerns the expenditure of Federal funds for aid to education. The Indianapolis Medical Society at a meeting on March 4th and speaking for more than 900 members, went on record as being opposed to any such legislation; and initiated a movement to bring its stand to the attention of all of the units of the Parent-Teachers Association in Marion County, Indiana. A letter was sent to each Parent-Teachers Association president stating in a most friendly manner the reasons for the Medical Society's position on this matter. It was brought out that its opposition to Federal Aid to Public Education was "consistent with its opposition to other Federal control problems, which can well mean eventual socialization of industry, business, and other free institutions." The letter continues as follows: "By no means does it mean that the Medical Society is "against" education per se but it does mean that we believe our schools can best be operated at the local and state level without direction from a bureau in Washington."

"The long record of the medical profession in its campaign for better school health programs, its advocacy of more hospital facilities and its interest in steadily making inroads on the diseases of children" tends to point up the interest of the profession in schools and related problems. However, the advances which have been made have been brought about by cooperative action in our state and in our own local communities without benefit of federal hand-outs or direction as to how those hand-outs should be spent."

"We believe, along with other responsible groups and individuals, that federal aid to education will, in the end, mean federal control of the public schools of this country. History has proved that no federal bureau can long resist the temptation to take full advantage of "purse string" opportunities to enlarge its own power and to impose its own thinking and its own inept management upon the state and local government service for which it provides part or all of the finances.

"Why should the doctors take a stand in this issue? We do not see how we can fight efforts to socialize the medical profession and, at the same time, blink at the same effort to socialize the free schools of the nation. Both are part and parcel of the same big effort—to direct this country down the painful road of state control, a route which has been so disastrous for so many nations which mistakenly believed they 'were getting something for nothing.' "

"We are joined, incidentally, in our thinking by such men as General Dwight D. Eisenhower, Senator Harry F. Byrd, Dr. Herman B. Wells of Indiana University, Dr. Frank H. Sparks of Wabash College, and many others."

In view of the information that the National Parent-Teachers Association organization was on record as favoring Federal aid to education and was holding its national convention in May in Indianapolis, the Indianapolis Medical Society also contacted other state and County Medical Societies, citing its stand and the reasons therefore, with the hope that similar action might be initiated throughout the country with a view to reversing the present stand of the National Parent-Teachers Association organization.

This matter was brought before the Committee on Public Medical Education of the Baltimore City Medical Society. The Committee by unanimous vote went on record as being opposed to any legislation which would approve the expenditure of federal funds for aid to education, and a letter similar to the above was mailed to the president of each P.T.A. group in the state of Maryland.

The two governmental proposals detailed above, serve but to emphasize the continuing attempts of the present administration to lead this country down the road to complete state socialism with its government subsidies, controls, regimentation, doles, and eventual elimination of individual enterprise and initiative.

"The American system has developed individual freedoms under constitutional democracy to the fullest measure ever known to man. It is the system which is always ready to supply the vital

spark needed by the deserving to expand mediocrity into genius. It is the system which supplies the incentive to every American to start at the bottom and rise to the top. It is the system which enables us with only six per cent of the world population to out-produce the rest of the world combined." So states Senator Byrd in his recent address at Los Angeles to the American Medical Association. Can Socialism or Communism equal this? The answer is clear.

In concluding, may I again quote from the inaugural address of Dr. Bauer. "This is the year in which we must decide whether we want this country to continue its majestic growth as the greatest Nation of free men the world has ever seen, or fall into lockstep with the decadent Socialisms and Totalitarianisms of the old world. This is the year in which we must live up fully to the proud privilege and responsibilities of citizenship which generations of Americans have worked, fought and died to hand down to us. This is the year in which we must rededicate ourselves to the full execution of our right of franchise." Can we as American citizens do less?

MEN OR MICE IN NOVEMBER?

AMOS R. KOONTZ, M.D.*

For years doctors have been bewailing their own lot and bemoaning the fate of their country. Most of this has been done in hospital corridors, doctors' coatrooms, and around hospital luncheon tables. The creeping blight of socialism is acknowledged and felt by all. What have most doctors done to halt its progress or to stop it? A great many (and some of our leading ones too) are so puerile and paltry as to say "We can't do anything about it, so we might as well accept it." There were probably also such men in 1776. Undoubtedly they left a vast progeny. They had time for procreation while their neighbors who believed in freedom were fighting their battles for them.

In Argentina recently all doctors were required to sign a statement of their political faith. If they stated that they believed in the wrong things, they lost their hospital appointments. Self-seekers who are planning the socialization of our profession, as well as that of all other phases of our national life, will, if they succeed, have us in the situation in which they can do the same thing for us.

* Chairman, Committee on Public Medical Education, Baltimore City Medical Society.

The big question now is whether we are going to take it lying down, or stand up and fight like men? Are we going to be men or mice in November? Those who are going to be mice may not even take the trouble to go to the polls to vote. They may spend the day playing golf or going hunting. The *men* will vote. Also they will see that the members of their families vote. Also they will remind their neighbors to vote.

I strongly urge that all doctors in Maryland do better than that. Maryland has a great medical heritage as well as a heritage of great patriotism. It is our duty then to see that the same thing does not happen in 1952 that happened in 1948—namely that only 50% of the people of the country voted in the Presidential election. Will you not join with us in agreeing to make no appointments in your office or elsewhere on election day, and in agreeing to see only emergency cases on that day?

We further suggest that doctors, the ladies auxiliary, and other allied organizations form groups and arrange to telephone everyone in their communities to ask them to go to the polls and vote. We cannot all believe in the same thing or the same candidates, but we can show enough

interest in the preservation of our American ideals to vote against the people whom we think are trying to destroy them. Groups should be organized to take people to the polls who have no way to go. If women with children need baby sitters, why could not doctors' offices serve as community baby sitting establishments? It is up to us. The time for mere talk is over. The time for action is here. It cannot be that there are many mice among the doctors in Maryland, but remember—you might as well be one as to act like one.

COMPARISON OF THE REPUBLICAN AND DEMOCRATIC PARTY PLATFORMS

It is interesting to note that this year's statement of policy on the health issue by the Democratic National Convention is considerably more moderate than the position taken by President Truman, and is also more moderate than the Party's previous position.

The Democratic Health Plank, while it advocates Federal aid to medical education, does not contain specific endorsement of National Compulsory Health Insurance.

As anticipated by medical leaders, when the President's Commission on the Health Needs of the Nation was created some six months ago, the Democratic statement of policy seeks to avert a showdown before the voters on the health issue by commending President Truman for the creation of a "non-partisan Commission to seek an acceptable solution of this urgent problem."

The Republican statement of policy on the health issue this year, as you will recall, was an unqualified declaration that "We are opposed to Federal Compulsory Health Insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight and debased standards of medical care." The Democratic plank is anemic by comparison.

HEALTH INSURANCE PLANK
1952 DEMOCRATIC PARTY PLATFORM

Medical Education: We advocate federal aid for medical education to help overcome the growing shortages of doctors, nurses, and other trained health personnel.

Cost of Medical Care: We also advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the costs of modern medical care have grown to be prohibitive for many millions of people. We commend President Truman for establishing the non-partisan commission on the health needs of the nation to seek an acceptable solution of this urgent problem.

HEALTH INSURANCE PLANK
REPUBLICAN PARTY PLATFORM

We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to federal bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. *We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care.* We shall support those health activities by government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection.

Component Medical Societies

ALLEGANY-GARRETT COUNTY

LESLIE E. DAUGHERTY, M.D., *Journal Representative*

The following article appeared in the Cumberland Evening Times:

Allegany County's medical profession is well on its way to providing assistance in event of direct attack or as a casualty clearing station for victims from metropolitan centers.

This is indicated in a report made recently to a meeting of the Allegany-Garrett County Medical Society and joint staffs of Sacred Heart and Memorial Hospitals by Dr. Leslie E. Daugherty, medical director of Civil Defense in the county.

Dr. Daugherty said while it is believed by all strategists the county will not be a target for direct attack, it is likely "we will be overrun by displaced persons from other areas such as Pittsburgh, Washington and Baltimore."

It was his opinion that adequate medical defense cannot be provided unless the assumption is made that atomic destruction is a possibility. Since one hit would almost certainly cripple transportation, demolition bombs are considered a much greater possibility, he stated.

"In any eventuality or threat, Allegany County becomes a target either by direct hit or being overrun by displaced persons," Dr. Daugherty said.

Dr. Daugherty said Cumberland has a population of approximately 40,000 and the smallest unit for defense is based on 10,000 which can be cared for by one casualty clearing station.

A station normally replaces existing organized facilities of an established hospital, he said, adding that there are two hospitals here, one in Frostburg and another in Westernport.

The county has been designated as a six casualty clearing station area. Under this Cumberland will have four, Frostburg and Westernport one each.

"Cumberland already has two well organized casualty clearing stations. One is near Memorial Hospital and one in the South-End, where, most likely, facilities will be needed in case of being overrun from the Baltimore area. Many first aid stations will be set up throughout the whole area to prevent the organized hospitals from being overrun by minor injuries and illnesses. Illness from epidemics due to disturbed water supplies and heating facilities and food distribution, will far outnumber direct injuries and every person must be made conscious of his responsibility and must be trained in first aid," Dr. Daugherty said.

"Parent teacher associations will be asked to supply all lay personnel, so that Red Cross nurse's training schools, hospital staffs and already trained first aid workers can train these people to not only assist themselves, but aid others in any emergency.

"Any other emergency can be a factory explosion, railroad train wreck, or fire in downtown Cumberland, at any time and does not need to be a major war or threat of war.

"So, it is incumbent on we as physicians and nurses, to see that Allegany citizens are adequately prepared to meet any emergency, or any great disaster," the director asserted, adding:

"Cumberland will have four great hospitals. An 800-bed hospital located in Fort Hill High School building and a 600-bed hospital located in Gephart School, Frederick Street. The capacities of Sacred Heart and Memorial Hospitals will be doubled. To do this, necessary personnel and medical and surgical staffs must be retained by the two hospitals and the rest released for the auxiliary hospitals.

"Equipment and supplies, medicines and instruments are already in Cumberland, or are on the way to equip these auxiliary hospitals and casualty clearing stations.

"Existing hospitals will be asked to carry on hand twice the amount of supplies at all times. Drugs will be kept fresh on a rotation basis. The local hospitals will be designated "Storing facilities" and supplies to be drawn upon by the casualty clearing stations," Dr. Daugherty stated.

The director said medical services, under the title "medical personnel" is made up of five categories: Physicians, nurses, dentists, pharmacists and auxiliary workers. These will be responsible

for procurement, training and assignment of personnel.

Daugherty said it is time for the two hospitals here to screen their staffs and assign auxiliary hospitals a complete and competent working force which could be activated immediately.

BALTIMORE CITY MEDICAL SOCIETY

PATHOLOGICAL SECTION

WILLIAM V. LOVITT, JR., M.D., *Secretary*

The May meeting of the Pathology Section of the Baltimore City Medical Society was held in conjunction with the Maryland Society of Pathologists, Inc. at the National Institute of Health, Bethesda, Maryland. Dr. Harold Stewart and his associates at the National Cancer Institute were hosts for the meeting and presented a very interesting scientific program. Summaries of the papers are as follows:

(1) A Case of Human Rabies Resulting from the Bite of A Rabid Fox, JAMES H. PEERS, M.D., National Institutes of Health, Bethesda, Md.

The subject of this report was a 32 year old woman resident of Dallas, Pa., a small town in the mountains above Wilkes Barre. Rabies was reported to be epidemic in the foxes of the area. The patient was attacked in her own yard by a fox which bit her in the left index finger through a glove. She strangled the fox, and the head, sent to the State Laboratory in Harrisburg, was reported positive for rabies. At the local hospital the finger was soaked in saline and peroxide and she was given penicillin and tetanus antitoxin. Two days later treatment with phenolized rabies vaccine was begun. After the eighth daily dose she began to complain of headache and pains in the knees and was admitted to the hospital. Because of fear of post vaccinal reaction, on advice of both the local consultants and the Medical Director of the firm manufacturing the vaccine, subsequent doses of the vaccine were administered in very dilute form and thereafter, she never received more than $\frac{1}{20}$ of the customary dosage, and mostly much less. For the following 11 days she presented at various times some symptoms of an allergic reaction to vaccine consisting of headache, joint pains and general malaise. During the night of the 20th day after being bitten she rather suddenly began to have swallowing difficulty, agitation and disorientation quite suggestive of furious rabies, but the consensus of medical opinion was that this was a hysterical reaction. However, her condition rapidly worsened; she became violently maniacal and then semicomatose and died in the early hours of the morning of the 21st day after being bitten.

Complete post mortem examination of the arterially embalmed body showed no significant gross abnormalities, but it was noted even then that the facies presented a notably "wild" expression. Extensive histopathologic examination of the brain showed only scanty lymphocytic infiltration about a few vessels in the midbrain and medulla. A number of cells in the substantia nigra and a few in the medulla showed various degenerative changes up to actual necrosis with little or no cellular reaction. In the cerebellum a number of the Purkinje cells, possible 1% of the total, contained 1 to 6 small Negri bodies, but showed otherwise little or no degenerative change. A few Negri bodies were also seen in the large cells of the hippocampal gyrus, tegmentum of the midbrain and reticular substance of the medulla. No perivenous microglial reaction in the white matter, characteristic of post vaccinal encephalitis, was present.

The case was thus one of furious rabies, not retarded by incomplete treatment and running the unusually short course of 21 days.

(2) Benign and Malignant Chordomas: A Clinico-anatomical Study of 22 Cases. CHARLES C. CONGDON.

Twenty-two cases of chordoma were reported. Four were benign and 18 malignant. The benign chordomas were incidental autopsy findings in three cases. The fourth case was found in a surgical specimen of the coccyx. None of them produced symptoms. The coccygeal case showed probable origin of the tumor from an intercoccygeal disk. Eight of the malignant chordomas were situated either in the cervical spine or on Blumenbach's clivus. Ten of the malignant chordomas were situated in lumbar vertebrae or in sacral and coccygeal segments. One of the lumbar chordomas at the time of operation was seen to arise from an intervertebral disk. The variations in the microscopic structure of chordomas

were illustrated and the problem of histogenesis discussed.

(3) Cancer in Domestic and Wild Animals. W. H. EYESTONE

A discussion of the comparative features of incidence and morphologic types of tumors in domestic and wild animals. In animals, as in man, tumors of the mesoderm are more common in younger age groups while ectodermal tumors tend to appear more frequently in the declining years. Some morphologic types of tumors, which are rare in man, such as mesotheliomas are seen with relative frequency in cattle. The mode of origin of certain tumors, such as seminoma of the testis in dogs and melanoma in the sheep, more clearly demonstrate the cells of their origin than comparable tumors in man. Certain tumors of animals, such as the mast cell tumors in dogs, have not been reported in man. A study of the various species of animals autopsied in Zoological Parks indicates that the overall incidence of cancer in these captive wild animals is similar to that in man, but that in primates, it is probably lower than in man.

BALTIMORE COUNTY MEDICAL SOCIETY

DONALD L. SOMERVILLE, M.D., *Journal Representative*

The Maryland Institute of Art was the scene of the June luncheon meeting of the Baltimore County Medical Association, which was held on June 18, 1952. This was indeed, a memorable, enjoyable and extremely interesting meeting insofar as this was the first time a medical meeting was held within such an artistic domain.

Luncheon was served in the Main Hall with the participants surrounded by beautiful paintings, drawings, statues, and figurines.

This was a joint meeting with the Woman's Auxiliary of the medical society. The Woman's Auxiliary granted a scholarship in nursing to Miss Carol Ann Wienefeld of Freeland, Maryland. She will have the opportunity of selecting her own school of nursing and the Woman's Auxiliary will handle all financial arrangements for the usual 3-year course.

The Committee on Public Relations gave the prizes to the winners of the recent art contest. Lee Einwaechter of Arbutus received a $50.00 Defense Bond for first prize, Margaret Grimm of Pikesville was given a red ribbon for second prize, and to Tom Riley of Towson, went a white ribbon for third prize.

The Society extended special thanks to Miss Margaret Glace, Dean of the Institute, who arranged this wonderful meeting, and to Miss Olive Jobes, Supervisor of Art in the Secondary Schools of Baltimore County who has so much to do in arranging the exhibits. Others who received commendation were Mrs. Florence Zavadil of Baltimore city who helped the physicians supervise the contest, and Mr. James B. O'Toole, Superintendent of Secondary Education in Baltimore County, with whose cooperation the contest was held.

Dr. Louis Krause of the University of Maryland School of Medicine gave a wonderful talk on "Life in Biblical Times." Dr. Krause has spent many summers in the Middle and Near East and he was able to discuss this interesting topic from personal experience.

A discussion regarding what solution might be reached in the Medical Care problem followed; Dr. J. E. Bradley, of the Council on Medical Care of the Medical-Chirurgical Faculty, spoke of various objections to the problem that have been raised in the past, and gave his council's answers to these objections. It was pointed out that with the cut in funds which the program faces for the coming year, it will be impossible to carry on this work as in the past, for the simple reason that the funds will be gone by March, 1953. Dr. Melvin Davis, of the Sherbow Commission, suggested that the Association devote an entire meeting to discussing the situation so that concrete suggestions representative of the Association as a whole might be sent to the Medical-Chirurgical Faculty, to be used in the form of an appeal to the State Legislature.

ST. MARY'S COUNTY MEDICAL SOCIETY

J. ROY GUYTHER, M.D., *Journal Representative*

The monthly meeting of the St. Mary's County Medical Society was held at St. Mary's Hospital. A motion picture was shown on "Cancer of the Uterus—The Problem of Early Diagnosis." The doctors of the staff pledged their support of the hospital expansion program that is currently under way.

Representatives of the Charles, Calvert and St. Mary's County Medical Societies met at Hughesville on June 19th to discuss the Medical Care Program. The meeting was conducted by Dr. Page Jett of Prince Frederick, who outlined the problems confronting the Medical Care Program and asked for suggestions and opinions of the group to remedy the problems.

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SYMPOSIUM ON TRAUMA AND ITS RELATION TO DISEASE*

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, October 24, 1952, 8:00 p.m.

PANEL DISCUSSION

Paul F. Due, Esquire, *Moderator*

1. Introduction:

   Paul F. Due, Esquire, President of the Bar Association of Baltimore City.
2. Panel Participants:

   Honorable Emory H. Niles, Supreme Bench of Baltimore City.
   Russell S. Fisher, M.D., Chief Medical Examiner.
   Joseph L. Lilienthal, Jr., M.D., The Johns Hopkins Hospital.
   Eugene Meyer, III, M.D., The Johns Hopkins Hospital.
   (Subjects to be announced.)
3. Question Period. Questions from the floor are invited.
4. Adjournment.

* Arranged by the Joint Committee on Medicolegal Problems of the Baltimore and Maryland Bar Associations and the Medical and Chirurgical Faculty, under the auspices of the Symposia Management Subcommittee which is composed of the following members: Mr. S. C. Berenholtz; Mr. W. L. Galvin; Mr. A. Sodaro; Mr. T. C. Waters; Dr. I. R. Trimble; Dr. R. C. Tilghman; Dr. R. S. Fisher and Dr. L. M. Krause.

* * * * *

THINK OF THIS!

Quacks are the greatest liars in the world—except their patients.

Benjamin Franklin
Contributed by D. L. R.

"Get-Out-The-Vote"

Library

THE CHARLES FRICK READING ROOM AND THE WILLIAM F. FRICK ENDOWMENT FUND

At the inauguration of the Dr. Charles Frick Library of the Medical and Chirurgical Faculty of Maryland, Dr. Samuel C. Chew, in his commemorative address, said, "Do we not well then to keep alive that memory of one so dear to some of us, so honored by all, and to re-consecrate it to-night by associating it forever with books. . . ."

Dr. Charles Frick was born in Baltimore on the eighth of August, 1823, and his death on the twenty-fifth of March, 1860, was the result of contacting diphtheria from a patient. In his short but active thirty-seven years, his accomplishments were many.

Before entering upon his medical career, he was employed as an Assistant Civil Engineer for the Baltimore & Ohio Railroad Company. However, he soon began his chosen profession, when he became a student of Dr. T. H. Buckler and completed his work at the University of Maryland in 1845. Each year his ability as a skilled physician and scholar became evident. He served as a resident at the Almshouse, a Vaccine Physician and a physician to the Maryland Penitentiary and to the Union Protestant Infirmary. He was a founder of the Maryland Medical Institute, which was designed to be a preparatory and supplementary school to medicine, in 1847, and founded the Baltimore Pathological Society in 1853. From 1856 to 1858, he was the Professor of Materia Medica at the Maryland College of Pharmacy until his appointment as Professor of Materia Medica at the University of Maryland. He held this post until his death in 1860.

Dr. Frick left many contributions to medical literature in his few years of strenuous and faithful work. His work is characterized by accurate and careful observation, by patient and laborious analysis and by familiarity with what others had done on the same lines of investigation.

In the early period of his medical studies he wrote his inaugural thesis on the subject of puerperal fever. His other contributions to medical literature were in the fields of pathology, animal chemistry, analysis of the blood in health and disease and renal pathology. The result of Dr. Frick's labors in the field of renal pathology was the publication in 1850 of *Renal Affections: Their Diagnosis and Pathology.*

In 1896, Dr. William Osler, President of the Faculty, was asked by Messrs. William F. and Frank Frick, brothers of the late Dr. Charles Frick, to lay the following proposal before the Medical and Chirurgical Faculty of Maryland:

(1) The Messrs. Frick will give $1,000 to be spent in the purchase of books for a library.

(2) They desire that such a library shall form part of the library of the Medical and Chirurgical Faculty.

(3) The works purchased shall relate to the subjects in which the late Dr. Charles Frick was especially interested, namely, diseases of the urinary organs, of the cardio-vascular system, and fevers, particularly the malarial fevers.

(4) They agree to give during their lifetime one hundred dollars a year to be used in the purchase of new books in connection with the Frick Memorial Library.

(5) They request that, if possible, a special room shall be set aside for this, in which also they can place a tablet indicating the nature of the Library, and probably also a portrait of Dr. Frick.

The Faculty accepted the proposal made by the Fricks and also the wish of Mr. Reverdy Johnson, a personal friend of Dr. Frick, to contribute the sum of $100 a year for the purchase of books for the foundation.

For many years the fund was made possible by the donations of the children of the late Messrs. Frick, Mrs. Henry Barton Jacobs and the Messrs. Frick.

In the year of 1927, the Faculty received the sum

of $20,000 from the estate of Mr. J. Swan Frick. This was to be known as the William F. Frick Endowment Fund and was to be used for the purchase of books and the care of the Frick Reading Room, which is now located in the present building of the Faculty.

The Faculty bookplate is used and the Frick Fund is so designated.

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"De-VOTE A Day to Democracy. VOTE November 4th!"

Health Departments

SOME OBSERVATIONS OF THE BRITISH SYSTEM OF CARING FOR THE AGED AND CHRONICALLY ILL

The aged and chronically ill person has been acknowledged by medical and lay people alike as the most important public health problem facing us today.

Great Britain, which began its effort toward meeting the problem earlier than we, has gained many insights which may be valuable to Maryland as our chronic disease hospital program proceeds.

In Britain, for example, the medical opinion that, given the right treatment, large numbers of old people who previously were counted as chronically ill and allowed to remain in bed until they died, can be so improved by modern methods of care that they are able to regain some degree of activity, has been confirmed.

Quite naturally a fairly large percentage of patients admitted to chronic hospitals remain indefinitely because of their disabling conditions, but this is not the whole story by any manner of means.

The excellent rehabilitative work being done at Cowley Road Hospital Geriatric Unit, in Oxford, (an integral part of teaching hospital association of Oxford University) through physical and occupational therapy, to point up one shining example, seemed of great significance to me.

The effect of rehabilitative efforts on many long-stay patients was most impressive, the improvement in their physical condition being matched by improvement in their mental state.

At Cowley Road I saw a man of eighty-five who had been a carpenter before admission, doing an excellent job of weaving. Rug making, lamp shade making, leather work and the like, are occupations in which age does not seem to be an obstacle to learning. The Red Cross, in a service called "The Helping Hand" provides an outlet for the sale of articles made by patients, supplying them with materials whose cost is later deducted from the sale of the handiwork with proceeds going directly to the craft-worker.

The Frail Ambulant

The "frail" ambulant offers a challenge to us, which if satisfactorily solved, will do much to keep state institutions from being cluttered with patients who would do equally well in less expensively-operated institutions or annexes with overseer care, and thereby leave hospital beds and facilities for those who require medical and nursing care of a high order.

These patients make up a very large group whose disability is often more one of age than of any particular disease. They are not ill enough to need permanent confinement to bed or well enough, in the absence of good family surroundings, to live normally at home. They often have quite long periods of relatively good health alternating with periods when they need medical care and attention.

The frail ambulant is the kind of patient that the family should be encouraged to care for until medical attention is required. At such times hospital space should be readily available.

Cowley Road Hospital operates on that basis. One example of case handling that impressed me was that of a mother who had been at the hospital. She showed great improvement and her daughter took her home on the understanding that the hospital would be available when the mother needed care that the daughter could not provide. The time came when the daughter wanted a vacation and requested the hospital to keep the mother for this period. Hospital space was found for her and care cheerfully provided.

Such two-way traffic between the chronic hospital and the home must be free of obstacles. Ideally the interchange should provide a fairly comfortable existence for the elderly. The occasional hospital experience will enable the patient to obtain the benefits of any advances in therapy, whether curative or palliative.

The Rehabilitation Program

As in Maryland institutions, in England, emphasis is placed on the importance of a thorough physical examination of all patients. On many occasions

it is found that older patients are suffering from acute diseases which call for the full use of facilities offered by a general, rather than a chronic disease hospital. The English system has established a close integration between the acute and chronic hospitals.

A complete cure is not always possible for the patient who needs general hospital care, but by careful treatment, many effect a considerable restoration toward ambulant existence. In the treatment of such patients, the aim is toward maintenance of function for as long as possible.

The British have found that many patients suffering from hemiplegia as a result of a stroke, can be taught to walk, clothe and feed themselves through a combination of treatment and physical therapy. In England, as here, even a fractured femur, whatever the age of the patient, need no longer be the prelude to a life of useless activity. These are only two of the many conditions that I observed being improved by careful and painstaking treatment.

Here in Maryland, as in England, once it has become possible to establish a turnover in a unit treating elderly chronics, the average length of stay that patients will remain in general hospital wards should fall rapidly and considerably.

Classification of Patients

In general, the English classify their patients somewhat differently from the classifications to which we are accustomed. Because the problem of rehabilitating the elderly is so much greater than that of the young, they separate older patients from the middle-aged and younger patients, largely for organizational rather than clinical reasons. At Cowley Road Hospital in 1951 only 13 per cent of the admissions were under 60 years of age. In the Northeast Metropolitan Region in 1949, an analysis of the 3000-odd chronic sick beds showed that 90 per cent were over 60 while the remaining 10 per cent were under that age.

Younger patients, specifically children with damaged heart or nephrosis, the infant with club feet, are handled at Wingfield-Morris Orthopaedic Hospital with middle-aged patients who have rheumatoid arthritis, ankylosing spondylitis and neuromuscular disease being handled through the newly opened Stoke Mandeville Rehabilitation Unit.

One feature of both the geriatric and pediatric hospitals that I found of interest was the "Long Stay Annexes." In the case of the young these are for long term disease and have teaching facilities. For the old, the Long Stay Annex has been used for selected confused patients, sufficiently fit physically to be looked after in part by a few nursing aides and by other patients who become interested and protect them. The Long Stay Annexes also house the frail "over-aged" patient who is competent mentally but without family and unable to care for his own needs.

The Follow Up Scheme

An effort is made to return as many patients as feasible to their own homes. No bedfast patient or patient in pain is ever sent home, but such patients as those with terminal cancer, requiring a great deal of nursing care have been returned under the follow up scheme. If it is possible to relieve their symptoms, improve their nutrition, and treat their anemia, they can and are sent home until readmission becomes necessary.

The Follow Up Scheme approaches the chronic patient as a social problem giving him what Dr. L. Z. Cosin, Director of Cowley Road Hospital; F. R. C. S., England; describes as "The dynamic quadruple assessment—pathological, sociological, psychological and assessment of the residual physical disability" with the provision of continued care from the Geriatric Unit. This continued care may include physiotherapy, occupational therapy and Day Hospital. It is supplemented by continued care from the community in the form of voluntary visitors, Meals on Wheels, social clubs, District Nurses, Health Visitor's education, home helps, municipal transport, friendly neighbors and the General Practitioner.

Combined, these services facilitate the resettlement of a large proportion of patients, even if they live alone on some occasions.

Beds per Thousand Population

The idea of large custodial institutions for the aged and infirm under the hospital authority (National Health Service) is beginning to give way to smaller, far more active Geriatric Units with appropriate Long Stay Annexes for Frail Ambulant and Senile Confused Cases. The ambulant patients become more and more the responsibility of the local social welfare authority.

Specifically, Cowley Road Hospital Geriatric Unit is serving a population of 250,000, with a total of 350 beds or 1.4 per thousand. Of these about 100 (0.4 of a bed per thousand) are the acute geriatric section. The other 250 beds consist of 50 Senile Confusional (40 Female and 10 Male), 150 Frail Ambulant and 50 permanently bedfast. Dr. Cosin believes the latter figure should be considerably reduced in the future.

Relationship of the General Practitioner

In Oxford, the Cowley Road Hospital Geriatric Unit is an integral part of the teaching hospital drawing 25 to 30 per cent of its admissions from The United Oxford Hospitals and Radcliffe Infirmary. The rest come from the medical practitioners' referrals and the general hospitals.

A close liaison is maintained with the Practitioner and the Geriatric Unit through the Follow Up Clinic and the Out-Patient service so readmission, when necessary, can be smoothly arranged. Dr. Cosin says the General Practitioners are responsible for the day-to-day care of geriatric patients under rehabilitation in the Long Stay Annexes, especially in rural areas.

Although we cannot see merit in the overall system of National Health Insurance as practiced in Great Britain, nevertheless, it seems to me that in the field of chronic illness, the English have advanced quite rapidly. Rehabilitation has been the keynote of their program. It surprised me to find that rehabilitation of the degenerated senile patient who is irresponsible mentally but physically still active has been successful in almost 25 per cent of cases and that almost all incontinent patients, in the belief of the English, can be retrained.

There is much in the rehabilitation of the aged and chronically ill that neither the English nor we know, but they have explored the field enough to be confident that it offers many unexpected possibilities. This is Maryland's challenge.

R. A. Riley

Director

ALCOHOLISM, A MEDICAL AND A SOCIAL PROBLEM

PAUL V. LEMKAU, M.D.*

It is trite to point out that alcoholism is no new problem in society. Yet it is perhaps necessary that it be done to make clear at the outset that it is not something to be easily managed by a turn of the "modern" medical hand. Alcoholism is not a specific disease for which we can hope to find a specific cure in the presently foreseeable future. It is a symptom of social unrest and psychological and possibly physiological maladjustment to begin with. In its acute stages alcoholism is, of course, a tissue intoxication or deprivation syndrome. The chronic states of deterioration and psychosis, which follow long periods of inadequate living, neglect of diet and tremendous imbibition of alcohol, are secondary to brain tissue destruction. The behavior patterns shown in these states are likely to be colored and conditioned by the social ostracism which drives the chronic alcoholic to the flophouse and skid row kind of sodden and unstimulating deteriorative type of life. In this process, there are both direct and indirect damages to other body tissues, but the chief interest, so far as personality function is concerned, lies in the damage to the central nervous system.

There is no conclusive scientific evidence at the present time to settle the question of why some people cannot handle alcohol. Of the 40 to 60 million people who use alcohol in the United States, only less than a million are believed to use it beyond what might be called the "normal" way, though of course there are those who point out that alcohol in the blood stream is not ever "normal." It is not a product of normal internal metabolism, but a drug deliberately introduced; therefore there is nothing "normal" in the ingestion of alcohol whatever. From the purely physiological view this reformers' prohibition point of view is certainly sound. But alcohol has a place in almost all human cultures to such an extent that its moderate and controlled use can hardly be thought of as abnormal when man and his culture are viewed as a whole. The excessive, uncontrolled, and by the individual, uncontrollable,

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use of alcohol is what is usually designated "alcoholism," and the inebriate, "an alcoholic."

The end point between "normal" drinking and "alcoholism" is indefinite, though many attempts have been made to fix the point. Everyone seems to agree that the "turning point" comes long before the social degradation to "skid row" that seems to be the premortal agony of many uncontrolled alcoholics. Some believe the diagnosis, self-diagnosis or medical diagnosis, should be made the first time an individual loses a day at work because of a hangover. Others feel this is too late—that the problem really was there far earlier, perhaps when the subject or his boss first realized that efficiency was lowered at times because of alcoholic intake. Again, the indicator has been taken as the first time the individual has a "black out," is unable to recall what happened during a period of alcohol consumption. This, too, has been said to be too late, and that the matter should become of concern whenever alcohol is taken with the intent to change the emotional state of the individual, and not only when consciousness itself is obliterated. By this definition, the person who fortifies himself with a cocktail before a difficult conference is an alcoholic, as is the person who takes a drink to overcome the shyness that makes interpersonal relations difficult or otherwise painful for him. Alcoholism is also said to be present when the individual appears to take the drug for the purpose of becoming able to say or do things which he would not do when in a state of full consciousness. Perhaps the most common area of action in this sense is the seeking for kinds of sexual experience which are taboo in our culture. The alcohol is drunk, often on a nearly or fully conscious basis, so as to have a convenient, ready alibi at hand, if society points the finger of guilt at the individual for homosexual or other types of sex behavior not easily tolerated in our culture. This same excuse is prepared for indulging in self-pitying criticism of others; one wife described her husband's carping, constant criticism when drunk as "he can really grind the organ when he's tight." Some drunken wife beaters drink because they want to beat their wives and find themselves too much gentlemen to do it when sober. When alcohol is used in this manner, it seems clear that it is fair to say that the state of alcoholism exists. This discussion of end-points of diagnosis is by no means complete, but it will serve as an indicator of the difficulties of definition encountered. On the other hand, it does not seem too difficult for the objective observer to recognize when drinking is going too far. Countless alcoholics bear witness that recognition or at least admission of the state is far harder for the person actually concerned.

What is the nosological position of the state of alcoholism? Is it a disease to be equated with, say, diabetes mellitus—perhaps more appropriately, diabetes insipidus? There are those who support this view, pointing to as yet inadequate data claimed to indicate that there appears to be an excess of diabetics in families of alcoholics as compared to the general population. It can be said, however, that this hypothesis, even if proved, which it is not, would not account for all cases. There is no demonstration that the carbohydrate metabolism of alcoholics is in any sense unusual. Alcoholism, if it is a disease, is not as clear-cut a one as is diabetes or the other pathological hormonal syndromes.

Alcoholism has also been called an allergic phenomenon, it being asserted that the drug has a specificity for the alcoholic that it does not have for others, that the alcoholic is sensitive to alcohol. There is no evidence for this and, of course, the idea falls down theoretically since specific sensitivities are usually due to much more complicated compounds than C_2H_5OH, and also on clinical grounds. The allergic person is seldom driven to test his allergy by taking larger doses of the allergen, even if it happens to be something as delicious as fresh strawberries. While the allergic theory has little to support it medically, it is, perhaps, useful as an analogy for educational purposes. Analogies are tricky teaching devices, however, and many patients carry away the concept that alcoholism is an allergic condition and not what was intended, namely, that in some respects it is something like an allergic condition.

Alcoholism may be conceived of in terms of a peculiar constitution characterized by autonomic imbalance. This imbalance is of such a character that alcohol acts to restore the balance. The success of the drug, however, carries with it side reactions which eventually make it ineffective and actually detrimental. It is, of course, known that various drugs tend to be substituted for alcohol by alcoholics. Barbiturates, paregoric, paraldehyde, chloral and other drugs, subserve the sedative function equally

well and may be depended upon when alcohol is foresworn or unavailable. These drugs are not so socially acceptable, however, in any case they are less commonly used than alcohol in our culture. The constitutional autonomic imbalance is usually supposed to be hereditary, illustrating a very common tendency to use heredity to explain something even though the evidence supporting its responsibility is simply that nothing else explains the situation either. There appears to be no unequivocal evidence that alcoholism is in any specific or near-specific sense dependent upon hereditary factors. The concept of "lack of will power" which explains so little, would probably fall into this general idea of causation.

It has also been hypothesized that alcoholism is a defense reaction of the person against the appearance of more severe mental diseases such as the paranoid psychosis or schizophrenia. The argument is that if the individual did not have the release of alcoholic sprees for his hostilities and aggressions, he would be forced into more severe personality distortions than alcoholism itself is. There is a little clinical evidence for this, but it is supported by no sound statistical studies. One does occasionally see alcoholic patients who become schizophrenic if withdrawn from the possibility of getting alcohol, but it is extremely difficult to say the schizophrenia was not there before also and could have been diagnosed had the patient been thoroughly studied. The psychoses dependent upon brain tissue destruction by or associated with excessive intake of alcohol often have symptoms reminiscent of other mental diseases, particularly the hallucinosis and the delusions. But it is known that brain trauma can release such psychotic symptoms regardless of the source of trauma, and there appears to be no specific character of alcohol in this respect.

Finally, there is the concept that alcoholism is not a disease at all, but a symptom of other disease, depression, elation, schizophrenia, the neuroses, or psychopathic states. Relating alcoholism to manic-depressive psychosis can explain the "cures" observed occasionally without treatment, since this type of psychotic reaction is known to be, in general, self-limited. Clinically, in my experience, alcoholism is occasionally a presenting symptom in elations or depressions, but it very quickly appears that it does not fit the pattern of gradually progressive increase in drinking of the problem alcoholic, but is more "punched out" in time. It is, of course, also associated with the predominant mood with its appropriate behavior.

Alcoholism is occasionally associated with the schizophrenic psychosis, but again, except in the vague diagnostic group of simple schizophrenia with such symptoms as social degradation and vagrancy, the symptomatic character of the alcoholism is quite clear. In the group of cases mentioned, diagnosis is extremely difficult. In such cases, particularly when no treatment is known, the physician is likely to choose the most serious of the possible classifications since the issue is often how to get the patient out of circulation and into hospital. Since at the present time, a diagnosis of alcoholism will accomplish this for only a short period, and a diagnosis of psychopathy probably not at all, the psychiatrist or physician may be quite reasonably reduced into labelling the problematical case schizophrenia to secure the desirable result in management of the patient and the acute social situation.

It is hardly worth while to discuss alcoholism and the diagnosis of constitutional psychopathic inferior or "psychopath." This diagnosis is almost always a symptomatic diagnosis based on the a- or antisocial acts of the patient in question. Alcoholism is, from the standpoint of society, a series of asocial acts. If it is combined with such antisocial activities as forging, stealing, possibly sex offenses (a matter requiring more elaboration than there is space for here), violence against persons, etc., then the alcoholism may be diagnosed a symptom of the general personality called psychopathic. It is at present an almost purely empirical diagnosis, though recent work on the effect of deficient maternal care in infancy and childhood may substantiate the possibility of etiological diagnosis in this field in the next few years.

Alcoholism as a neurotic symptom has probably been discussed more than the other categories already taken up. The concept has already been suggested in dealing with the postulated autonomic imbalance discussed earlier. The psychodynamic hypothesis of the etiology of neurosis is that, whatever the basic constitutional level of reactivity, autonomic function can be varied through emotionally charged experiences lived through by the person. If the experiences have negative effect, the autonomic functions are adversely affected so that the

usual neurotic symptoms appear. In some instances, the adverse effects are on the thought and feeling patterns so that tension and obsessive states and chronic anxiety appear. In some cases, alcoholism is resorted to in an attempt to allay the uncomfortable thoughts and physiological overreactions.

Alcoholism is also conceived very much more simply by some, so simply that professional suspicion is at once aroused. Alcoholism is simply conceived of as a habit run wild, simply the gradual increase of drinking until the individual is caught and can no longer escape the net of habit constructed on the basis of a very simple learning theory. Few defend this view, though all agree that if it were not for the opportunity in our culture to get alcohol, alcoholism per se would not be a problem. The symptom might be "foodism" with resultant problems of obesity, or excessive sex activity, or perhaps some type of more or less objectionable reformism, if not some worse outlet.

In summary, theories of the etiology of alcoholism are very many and none of them can be said to be proved. It is highly probable that so complicated a reaction as alcoholism will not be explained on any one theory, but will, like most social-personal reactions of illness, be found to have large numbers of factors combining to force the individual into this syndrome.

Treatment Theories

Theories of treatment should rest on theories of etiology, but as every practitioner knows, they are likely to be contaminated by empiricism to a very high degree. As physicians, we tend to use what works in treatment, we are frequently more anxious to help than we are to explain why and how our help is effective. Boils were lanced before the theory of inflamation and its microscopic demonstration were completed, and electroshock is used although we are hard put to demonstrate just why it helps patients. Many other examples could be used to demonstrate this familiar practical issue. In the treatment of alcoholism the same empiricism dominates the field. There are some relationships between treatment methods and theories of etiology to be sure, but in most treatments anything that seems to help is grasped and used, and the theory is left to the theoreticians. Nevertheless, an attempt will be made to discuss various therapeutic methods in a somewhat systematic fashion. Although it is true that physicians and psychiatrists treat empirically, the consumer often believes treatment to be specific. In the case of alcoholism, the public, on the other hand, seems inclined to blame the medical profession and perhaps particularly the specialty of psychiatry because there is some insistence on having at least a modicum of theoretical justification for a treatment program. This is a common complaint of the Alcoholics Anonymous group which believes it has a method for producing results and is impatient with efforts of the theoretician to explain how they are obtained. At the outset, it should be made clear that the treatment of acute alcoholic intoxication is not the concern here. There are many methods of detoxifying the patient and restoring acute deficiency of nutriments which deserve exposition, but here the concern will be for the treatment of the chronic condition of drinking immoderately.

Insight therapy aims to aid the patient to reach an understanding of his personality and of the forces which form the basis for the dissatisfactions and maladjustments which lead to the symptom of alcoholism. The etiological theory behind this is, of course, that alcoholism is fundamentally a symptom of some mental illness which can be cured by psychotherapy. This type of therapy, whether performed by a psychoanalyst or by some other type of analytic and synthetic method, has not proved very successful and has led the public and alcoholics in particular, to look askance at psychiatric attempts to cure. The explanation for this situation is not easy to find. One might approach the problem from the point of view that the whole psychogenic hypothesis is a colossal mistake, or at least that it has no applicability in the case of the alcoholic. This would certainly be throwing the baby out with the bath, for the hypothesis does not rest on experience with alcoholism alone, but on the whole field of psychopathology where evidence more favorable to it exists in ample amount. The answer probably lies in two points, first that the alcoholic who can afford psychiatric treatment is either not at that nadir of social disintegration from which he turns with great remorse toward any savior since things can get no worse and he live, or it may be that the alcoholic who can afford the treatments is being urged to accept them by someone who is footing the bill so that he himself is not much concerned. Alcoholics are no-

torious for always verbalizing that they want to stop drinking but failing to carry out their promise to themselves to stop until some critical turning point. All methods of therapy seem to agree that very little success can be obtained with patients who do not wish to be cured.

The second, and possibly more important reason for the failure of psychotherapy with alcoholics is that the psychopathology involved is of a type related to that of the psychopathic personality, a group of cases where psychotherapy is also notoriously unsuccessful. The problem would be stated then in terms of such fixed psychopathology of such deeply repressed origins that it cannot be brought to yield to any analytical type of treatment. Psychiatrists are human and, like other physicians, like excuses for their failures. To psychiatrists, then, this formulation of the problem is likely to be satisfactory though to others it is likely to be seen otherwise. It is probable that the psychiatrist and indeed all medical men frequently fail with alcoholics because they see patients too early, before the lowest point of social degradation and therefore do not have the advantage of the deepest remorse and resolution that would appear to be a sort of agonal response giving a sensitive opportunity for therapy at the "psychological time." The police, the judge, the warden and the member of Alcoholics Anonymous gets the advantage of this agonal response. Hearing Alcoholics Anonymous meetings and reading Alcoholics Anonymous stories gives the impression that "hitting bottom" is part of recovery, though the "bottom" is not equally low for all.

The next medical type of treatment to be considered is based on much more mechanistic and superficial psychology than psychotherapy. It attempts to arrest the drinking through setting up a conditional response of nausea and distaste whenever alcohol is smelled or drunk. The alcoholic, after he has recovered from the acute intoxication, is given alcohol and then made to vomit, usually through the use of apomorphine. The process is repeated until a reflex of vomiting to alcohol is set up and the emetic can be withdrawn from the reflex system. Successes have been reported for the conditional reflex treatment though it is less popular now than a few years ago.

More recently the drug "antabuse" has been used. Antabuse reacts with ketones normally occurring in the blood during the metabolism of alcohol. A response ensues which is most uncomfortable for the patient. Nausea, retching, flushing are severe; apparently the reaction is not one the patient cares to repeat. The risk to life is small though it must be considered carefully since deaths have been reported. The difficulty in antabuse treatment is that the patient must continue to take the drug in order to have the unpleasant reaction to alcohol. Apparently there are those able and willing to take the drug as an additional insurance against weakening and taking a drink and with these persons "antabuse" appears to aid in maintaining abstinence. The treatment is enjoying a wide vogue at the present time.

There is an additional group of therapies which may be called "replacement treatment," therapies in which something is substituted for alcohol. The substitute may be chemical or psychological. Benzedrine had a vogue and is still used to offset the depressed, tired feeling that the alcoholic can so easily use as an excuse for a drink and to induce the state of "brilliance" the alcoholic frequently has the conceit to believe he shows when drunk or nearly so. Benzedrine has proved a deceitful ally however, since it can lead to addiction of sorts with psychotic aftermath hardly less damaging than those due to alcohol itself. Nevertheless it still has its uses. Sugar in various forms has also been substituted for alcohol, the theory being that the alcoholic at first is responding to a need for quickly metabolizable carbohydrate. Both these and similar methods which have been proposed have the psychological advantage that they are received through the mouth, a matter of some importance in some systems of psychopathology. On the basis of experience in therapeutics, as well as in the light of the known tendency for alcoholics to seek substitutes for alcohol which may be more seriously addicting and socially damaging than alcohol itself, it can be said that the substitution of drugs for alcohol is not generally a successful form of therapy.

Finally, there is the group of psychological replacement therapies in which attachments to people or concepts are used with such emotional force that the tendency to drink is overcome through the satisfaction of the needs of the drinker through other channels. While this type of treatment is very old and is used as a part of therapy by almost all success-

ful psychiatrists in the field, it has been used far more by non-medical than medical persons. Religious conversion experiences have been known to "cure" alcoholics for centuries and some of such cures were permanent, as can be proved in many biographies. At the present time, Alcoholics Anonymous is the recognized and organized instrument in our culture carrying on this type of therapy with conspicuous success. The functioning of this organization has been discussed many times in medical and psychiatric literature. The discussion here will be very brief for that reason.

For drinking, Alcoholics Anonymous substitutes group identification and morale, devotion to a cause reinforced by constant labor and sacrifice for the cause, certain practical and simple moral tenets and pieces of wisdom, and an humble bowing before a "Power" Who can aid the alcoholic to overcome any arrogant pride he may have that he can control himself, not only in regard to alcohol but in other areas of life as well.

The admission that the drinker cannot control his drinking is primary. The concept is that the alcoholic cannot ever again drink. Every introduction begins: "My name is John Doe and I am an alcoholic," usually followed by the story that convinces the man himself that this is a true statement though it contains the admission that this knowledge came only after many, many repeated lessons. This statement is the ticket of admission to Alcoholics Anonymous though it may also be added that there is the implication that there is a sincere wish to stop drinking. Stopping drinking, however, does not change the situation as regards alcoholism—the member *is* an alcoholic and believes he will always be so, even though not drinking.

This admission ticket allows the alcoholic to enter an organization of others with drinking histories and experiences as complete and thorough as his own but who are striving, many with success, for complete abstinence. The similar past experience of the members makes it impossible for the alcoholic to use the excuse "you don't understand"; indeed this excuse of the alcoholic is a recognized mechanism so familiar that reference to it will usually bring a laugh from a group of members. Many other familiar projection mechanisms are useless to the alcoholic once he has admitted his fault in the initial statement "I am an alcoholic." The high sense of belongingness and of morale has a slight tendency to be exclusive, though this is actively striven against in attempts to keep the organization avilable to all who need it or have a legitimate scientific interest in it.

The Alcoholics Anonymous member imposes upon himself the duty of helping other alcoholics whenever called upon to do so and many members make enormous personal sacrifices to aid their fellow sufferers in personal ways—arranging hospitalization, lending messages, providing clothing and food and sodging, helping find jobs, etc. This is done frankly for the purpose of helping not only the alcoholic now drunk, but as a means of keeping the sober alcoholic helper abstinent. The person helped is brought to a meeting as soon as possible and there he hears the experiences of others and discussions of the moral tenets and wisdoms of the organization.

These are not very complicated. They demand mainly the absence of decit of self and of others. "Take it easy," "Live one day or hour at a time," "May I accept what I cannot change" are rather typical. A "personal inventory" is suggested which is to a large extent a recounting of past wrong actions, attitudes and modes of thinking. As noted above, it disposes of some of the common dangerous psychic mechanisms and demands that they be recognized as sick and wrong. The Alcoholics Anonymous member regards himself as having a disease which is effectively held at bay by abstinence, honesty with himself and his fellow A. A. members, by service to others and finally by a belief in God though in no definite theological system.

Humility to admit weakness and knowledge of the weakness of other humans leads to acceptance of need for guidance from a Power beyond man that is, for some members, obviously part of a deep and satisfying religious experience though frequently coming about in a setting of simple camaraderie.

Summary

This paper has attempted to discuss some of the theories of the etiology of alcoholism. For the author, the most appealing one is the psychodynamic one, though in all probability the final answer will be contributed to by research in this area, in physiology and possibly in genetics as well.

Therapeutic methods have been reviewed in terms of psychotherapy of the analytic and synthetic types,

of the use of psychological mechanisms of learning, of substitution of other substances for alcohol, and finally, the substitution of satisfactions arising out of powerful emotional attachments to others, certain moral concepts and wisdoms and a belief in some higher Power.

It would appear that there are many forces that can be used in the control of alcoholism and in its treatment, but the application of them in the practice in medicine will require a great deal of research.

The paper has not by any means settled the nosological problem of alcoholism as a disease. The definition the paper started with, "it is a symptom of social unrest and psychological and possibly physiological maladjustment," is as good as can be suggested.

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SOUTHERN MEDICAL AUXILIARY INVITES WIVES TO MIAMI

The Southern Medical Association meets in Miami, Florida, November 10th–13th, 1952, and all indications are that it will be a meeting to be long remembered. The hospitable Miamians are going all out in planning a delightful social program for the ladies. A tentative Auxiliary program is as follows:

Sunday, November 9th.....	Special Executive Committee meetings
Monday, November 10th.....	Luncheon for Past Presidents
	Luncheon for Councilors
Tuesday, November 11th.....	Executive Board Breakfast
	General Sessions
	Doctors Day Luncheon
	Other social activities, including a Fish Fry on the beach
Wednesday, November 12th...	General Sessions
	Luncheon honoring the President, Mrs. V. Eugene Holcombe, the President-Elect, Mrs. Richard Stover, visiting State Presidents and Charter Members
Thursday, November 13th.....	Executive Board Banquet

The Auxiliary to the American Medical Association will furnish two of the speakers. Mrs. Ralph B. Eusden, President of the Auxiliary to the A. M. A., will discuss the aims and general program of the Auxiliary, and Mrs. John McCuskey, a vice Chairman, will speak on nurse recruitment.

Councilor for the Woman's Auxiliary to the Southern Medical Association is Mrs. Frank A. Holden, of Baltimore, Maryland, and Vice Councilor is Mrs. Thomas A. Christensen, of College Park, Maryland.

Wives attending the Southern Medical Association meeting with their husbands are cordially invited to attend all activities of the Auxiliary.

ALL RESERVATIONS FOR LUNCHEONS SHOULD BE MADE EARLY.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, August 1–28, 1952

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County	3	—	1	3	3	—	3	4	2	—	—	—	—	22	2	12	—	2
Anne Arundel	5	—	1	—	—	1	2	4	1	—	—	—	—	10	—	4	—	2
Howard	—	—	—	—	—	—	—	—	—	—	—	—	2	2	—	—	—	—
Harford	—	—	—	2	2	—	3	2	1	—	—	—	—	4	—	2	m-5	—
Carroll	—	—	—	—	2	—	—	2	—	—	—	—	—	3	1	1	—	1
Frederick	1	—	4	—	13	—	4	4	1	12	—	—	—	1	—	—	—	—
Washington	—	—	—	—	—	—	—	1	—	—	—	—	—	7	—	1	—	2
Allegany	—	—	—	—	—	—	1	—	2	1	—	—	—	5	—	—	m-1	—
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Montgomery	—	—	2	—	—	—	7	—	1	—	—	—	1	21	—	2	—	2
Pr. George's	1	—	—	—	5	—	4	3	—	1	1	—	1	17	—	3	—	1
Calvert	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—	—
Charles	—	—	—	—	—	1	—	1	—	1	—	—	—	3	—	—	—	—
Saint Mary's	—	—	—	3	—	—	—	1	—	—	—	—	—	1	—	—	—	—
Cecil	—	—	—	—	—	—	—	—	—	—	—	—	1	2	—	—	—	2
Kent	1	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	m-1	—
Caroline	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	7	—	—
Talbot	—	—	—	—	1	—	—	—	—	—	—	—	—	4	2	8	t-1	—
Dorchester	—	—	—	—	7	—	1	—	1	—	—	—	—	—	—	—	—	1
Wicomico	—	—	1	1	—	—	—	—	1	—	—	—	—	2	—	20	—	1
Worcester	1	—	—	—	—	—	—	1	—	—	—	—	—	1	1	1	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Total Counties	12	0	9	9	33	2	25	23	11	15	1	1	5	113	7	61		15
Baltimore City	8	0	1	2	10	0	25	10	0	6	0	0	2	104	15	581		8
State																		
Aug. 1–28, 1952	20	0	10	11	43	2	50	33	11	21	1	1	7	217	22	642		23
Same period 1951	33	2	12	13	274	1	63	15	8	7	2	4	28	155	24	664		16
5-year median	21	8	6	—	31	4	46	33	13	15	4	2	133	208	76	716		29
Cumulative totals																		
State																		
Year 1952 to date	2731	7	825	162	9058	68	886	55	29	821	15	12	151	1889	125	4848		477
Same period 1951	2671	31	837	177	5271	44	3550	32	35	708	10	21	340	1806	232	4773		366
5-year median	3026	146	380	—	2889	92	1175	58	48	862	22	31	902	1919	921	4988		483

m = malaria; all were contracted outside the U. S. A. except 1 from Aberdeen Proving Grounds, residence unknown.
t = tetanus.

BLUE CROSS AND BLUE SHIELD

BLUE SHIELD

HUGH J. JEWETT, M.D.*

The revisions in our Blue Shield Plan which were discussed at the April meeting of the House of Delegates and at subsequent meetings with component societies, will become effective September 1.

The revised Plan is the result of State-wide cooperation of all of us, as individuals and as groups, to bring about a better prepayment medical care program for this area.

It was only natural that not long after the Plan got underway in November of 1950 the need for certain adjustments and improvements began to become apparent.

By mid-summer of 1951, sufficient experience had been gained by the Plan for its Board of Trustees to consider changes which would make the Plan more acceptable to the public and more equitable to the physicians.

It was felt that there should be a revision in the subscription charges, particularly in the rate for family subscribers, and that the income limit for service benefits for this group of subscribers should be increased.

It was also decided to adjust the Schedule of Benefits, eliminating the categories and setting up a standard type of fee schedule which would be more equitable to physicians, and also to subscribers whose incomes exceeded the established limits. This revision in benefits was undertaken by a committee headed by Dr. I. Ridgeway Trimble. Based on this new schedule of fees, a study of necessary subscription charges was undertaken by the Plan's actuaries.

The Board of Trustees accordingly asked the Council of the Faculty for permission to increase the family income limit. The Council gave approval, in principle, but referred the matter to the House of Delegates at the annual meeting in April of 1952. The component societies of the Faculty thereafter considered this proposal and an overwhelming majority approved an increase in the family income limit to $4,000.

Under the revised Schedule, a separate benefit has been set for each type of operation, ranging from $10.00 to a maximum of $200.00.

Among benefit changes, the benefit for normal obstetric delivery has been changed to $80.00 and will not include pre-natal or post-natal care beyond the hospital stay. (Family subscribers enrolled before September 1, 1952, will receive obstetric benefits under their original membership certificate, instead of the revised certificate, until June 1, 1953.) This revision makes possible a substantial reduction in the subscription charge for families, and it is hoped that this lower rate will make the Plan more attractive to this group.

The new monthly group rate for a one-person membership is $.90, for husband and wife, or one parent and one child (no obstetrics) $1.80, and for the family (husband and wife and all children under 19 years, including obstetrics) $3.00.

The State Insurance Department has given its approval to the revisions in the Plan, and the administrative staff is prepared to offer the new program to all Blue Cross groups as rapidly as possible.

Every Blue Shield subscriber is receiving an announcement of the changes, together with a new membership certificate.

A new instruction manual for Participating Physicians has been prepared, including the complete new fee schedule, and a copy will be mailed to all physicians prior to September 1st.

A revised claim form also has been developed, intended to simplify the paper work for physicians in handling cases under the Plan.

The Board of Trustees, the Plan's administrative staff, and many others less directly concerned have spent much time and given careful study to this matter, and every effort has been made to make the Plan attractive to the public and equitable to physicians. It may not be perfect in every respect, but those who are directly responsible for its operations feel that it is a much improved Plan, and that real progress can now be achieved in extending prepaid health protection to the people of Maryland.

* President, Board of Trustees, Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

PROGRAM

Mrs. JOHN G. BALL, *Chairman*

Do you know the "Program" of our Maryland Auxiliary and of its parent body, The Woman's Auxiliary to the American Medical Association?

How can we best work together to assist the Faculty and the American Medical Association, to cultivate friendly relations among physicians' families and do a good job with Public Relations, so we may truly be an "Auxiliary"—or a help? Our first aim in all our meetings is to keep posted on the various phases of the "Program" as indicated below! There are many subjects and many interesting ways for Chairmen to present them so that the informal social meeting is not lost.

The American Medical Association has a wealth of material which can be obtained, sorted and organized into informative, newsy briefs. Subjects on the Aging, Chronically Ill, Narcotics Addiction, A. M. A. Services, articles in the popular press such as, *I'm a Doctor and I'm a Human*, are all possible meeting material.

A popular part of the program for Maryland during the coming year will continue to be, "Nurse Recruitment." Arrange to show the film, "Girls in White," to your Junior High Girls. We can now obtain this film from National without charge. Plan a follow-up tea or get together for any girls who are interested! Encourage the ideals of service to your own community and of Nursing as a responsible profession which is more than "just a good job."

Civil Defense will be extremely important in all of our communities. The American Medical Association *expects* us to lead in this field! Auxiliary members should take the Red Cross First Aid Courses, give blood, and help with our block questionnaires. Advice on good program material can be obtained from your local Civil Defense Office. Remember that doctors' wives are needed in the Casualty Clearing Stations as Volunteers!

"Public Relations" is interwoven throughout the Auxiliary Program but it comes to the fore at the County Fairs. Try to plan an Auxiliary Health Booth at which American Medical Association literature can be distributed during your Fair.

This is an important election year, check your Auxiliary members and their husbands to be sure they are registered voters and *do vote*. What about the other doctors in your community? They and their wives can find the time to vote, if they are reminded!

Remember that your State Officers are ready and willing to help with suggestions or material for your Component Auxiliary. Your State President would be happy to attend your County meeting. Plan your 1952–53 Program *early* and include some or all of these suggestions.

* * *

AMERICAN EDUCATION

We are all gradually awakening to the widespread left-wing effort to communize or socialize not just the medical profession but our entire Country through "thought control" in all of the available means of communication, including schools—from kindergarten through college, literature, the theatre, movies, public libraries, organizations and even our Churches and Sunday Schools. To stop this infiltration we must first inform ourselves by reading such articles as these from which we quote.

I. "The United Nations Charter authorizes a host of *autonomous specialized* agencies, such as the *International Labor Organization*, the International Court, the UN Economic and Social Council, and the UN Educational, Scientific, and Cultural Organization (UNESCO). This latter organization has sponsored nine booklets under the title: *'Toward World Understanding.'* They deal with the ideas to be *inculcated* in our children from kindergarten through grade school. One pamphlet is on *The U.N. and World Citizenship;* another, *The Influence of*

Home and Community on Children Under 13 Years of Age.

In describing this series, Congressman Wood states: 'The program is quite specific. The teacher is to begin by eliminating any and all words, phrases, descriptions, pictures, maps, classroom material or teaching methods of a sort causing his pupils to feel or express a particular love for, or loyalty to, the United States of America. Children exhibiting such prejudice as a result of prior home influences—UNESCO calls it the outgrowth of the narrow family spirit—are to be dealt an abundant measure of counter propaganda at the earliest possible age.' (*The Greatest Subversive Plot in History—Report to the American People on UNESCO, John T. Wood, Congressional Record, October 18, 1951.*)

"UNESCO urges that teachers of children from 3 to 13 shall not take up American history and geography but concentrate on 'universal history and geography' until the children are freed from their 'nationalist prejudices.' Following this advice, some schools in eastern Pennsylvania 'have dropped American history as a standard, required subject'"—*From Challenge To Socialism, Marjorie Shearon, February 1952.*

II. "Miss Helen E. Haines has more to do with determining what books go on the shelves of your public libraries than anyone else in the whole country. A few months ago Columbia University Press brought out a new and revised edition of Miss Haines's magnum opus, *Living With Books.* Since it was first published in 1935 *Living With Books* has become the Bible of librarians everywhere. In the 10,000 or more public, private, high school and college libraries of the United States, no textbook for librarians is more highly regarded. It is as the *Bookman's Manual* declared, 'the standard compendium of the art of book selection.'

"There is, however, a profound—and dangerous—difference between the 1935 edition and that of 1950. For at some point in the intervening years Miss Haines 'discovered' Soviet Russia and the Communist philosophy. Like all new converts, she has lost no opportunity in revising her book to play up her discovery. In fact, the major impression I get from a comparison of the original with the revised edition is the strong pro-Soviet bias of the latter. Miss Haines may think that she is still objective, but in fact she has now become a propagandist for the Stalinist way of life.

"The prestige enjoyed by Miss Haines's book has carried over to this new edition. Without doubt large numbers of libraries are already selecting books based upon her recommendations, without knowing that the cards have been stacked."—From *A Slanted Guide To Library Selections.* The Freeman, January 1952.

III. "With varying degrees of success, all four of the major aims of the communists in Hollywood were achieved: (1) Hollywood was 'milked' for vast sums of money. (2) Communist causes and fronts were glamorized by Hollywood celebrities. (3) The extent to which the communist line was smuggled into the script of films is debatable. Certainly, such pictures as Song of Russia, Mission to Moscow, and North Star were saturated with pro-Kremlin propaganda. (4) The communists for years controlled the Screen Writers Guild, even during the incumbency of the self-proclaimed anti-communist Emmet Lavery. The failure of the communists to capture the Hollywood unions took vigorous fighting on the part of the loyal Americans like Roy Brewer in the labor movement." (This article lists an alarming number of your favorite *movie* stars who are communists or communist sympathizers. The names will shock you.)—From *Did The Movies Really Clean House?* American Legion Magazine, December 1951.

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AUXILIARY NEWS

Mrs. Howard W. Ash, Past President of the Woman's Auxiliary to the Frederick County Medical Society, is now living in Evanston, Illinois, while Dr. Ash completes a two year residency in Ophthalmology at the Eye and Ear Hospital there.

The New Edition of our "Auxiliary Handbook" is now available at thirty-five cents a copy or three for a dollar! Every Auxiliary will probably want this guide for its Officers and Chairmen. It is obtainable from The Woman's Auxiliary to the American Medical Association, at 535 North Dearborn Street, Chicago 10, Illinois.

Miss Margaret Wolfe, for so long the wonderful Executive Secretary of the National Auxiliary and a doctor's wife, herself, is to our great regret, re-

tiring. The new Executive Secretary to whom we will all be writing for material and help is Mrs. Dorothy K. Middleton, at the American Medical Association Headquarters in Chicago.

The Baltimore County Auxiliary held a banquet jointly with the Medical Society in June, and are now planning a "Barn Dance" perhaps in costume, for fall!

Our State President, Mrs. Charles H. Williams, purposely delayed her Post-Annual Board Meeting until her return from the National Convention of the Woman's Auxiliary to the American Medical Association which was held in Chicago in June. We understand that she brought back a great many new ideas to her Officers and Chairmen for Auxiliary work.

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MORE THAN MEETS THE EYE?

"If Mrs. Alice Tisdale Hobart had managed to devise a suitable ending for her 402 page novel, *The Serpent Wreathed Staff*, about sixty pages sooner than she did, a tolerant critic would be able to say that she had written a faulty but highly interesting story of human conflicts and loyalties.

"Unfortunately, however, the latter part of the book degenerates swiftly and recklessly into an amazing propaganda piece for National Compulsory Health Insurance. The last forty or fifty pages sound as if Mrs. Hobart knocked them out hastily at a desk piled high with pamphlets, speeches and news releases handed out by Federal Security Administrator Oscar Ewing and The Committee for the Nation's Health.

"This uncraftsmanlike abuse of artistic license added to some of the implications built up in earlier pages, creates the impression that the entire novel was designed as a subtle presentation of the case for Socialized Medicine. As a result, Mrs. Hobart undermines much of the validity that does exist in some of the earlier parts of this book about doctors, modern medicine and a changing world."—From Book Review mailed us by the American Medical Association.

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QUOTABLE QUOTES

"Bad politicians are elected by good people who do not vote," from a speech made at the recent National Auxiliary Convention in Chicago.

"Put none but *Americans* on guard tonight." (Don't Elect an "America-Last" President!)—George Washington.

"By 1954, medical graduates will have increased by 22 per cent over 1940. By 1960, the year of the alarming shortage feared by Washington politicians, we'll have more doctors in proportion to population —and better ones—than we have today."—*What about This Doctor Shortage?*—Readers Digest, June 1951.

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Ancillary News

DENTAL SECTION

A. BERNARD ESKOW, D.D.S., *Journal Representative*

BALTIMORE CITY DENTAL SOCIETY

The regular scientific sessions of the Baltimore City Dental Society were brought to a close for the summer at the May meeting. As is customary the regular outing was held at the Country Club of Maryland on June 17. It was a day of rest and relaxation for the men and included the usual golf, horseshoe pitching, tennis, softball, etc. It was followed by a catered dinner at which time for second year winners on two-year permanent trophies were announced. For golf it went to Dr. Edward (Middlecoff) Stinebert and for horseshoe pitching to Dr. Guy Lyon. The attendance was excellent and all the men seemed to have had an enjoyable day.

The city dental society is now busy at work getting ready to play host to the Maryland State Dental Association for its Semi-Annual Meeting sometime in the latter part of September. The details of the meeting have as yet not been released. However, they usually include both a scientific and social section.

NURSING SECTION

M. RUTH MOUBRAY, R.N.,* *Journal Representative*

PURPOSE OF RED CROSS VOLUNTEER NURSE'S AIDE PROGRAM

Noting the steady expansion of the volunteer nurse's aide program during the past 2 years, the Red Cross this month issued a statement to clarify misunderstandings that have developed concerning the objectives and limitations of the program and to reemphasize the responsibilities of professional nurse leadership in safeguarding standards.

While the volunteer nurse's aide program was familiar to many nurses during World War II, when more than 215,000 aides gave nearly 43 million hours of service, it is apparent that the present-day program is new to many nurses.

The volunteer nurse's aide program is designed to prepare a group of women and men not previously trained or engaged in any form of nursing practice to give volunteer assistance to professional nurses. These trained volunteers may give service in hospitals, clinics, in the Red Cross Blood Program, or with public health nursing organizations. They also constitute a reserve to help in disasters, epidemics, and similar emergencies.

The Red Cross is not responsible for training aides for vocational or paid employment and does not consider its training course suitable for this purpose.

Since the volunteer nurse's aide program involves technics of nursing that must be directed and supervised by professional nurses, the local Red Cross chapter committee responsible for the program is composed of both nurses and non-nurses. This committee determines the need, selects and assigns the aides, and interprets the service to the general public. The professional nurses on the committee:

1. Assist in evaluating the nursing needs when requests for nurse's aide service are received.
2. Interpret the program to professional people and maintain relationships with professional groups in the community and in the institutions where aides work.
3. Approve hospitals or health organizations for training or for service to assure adequate professional supervision and acceptable standards of nursing care.
4. Approve qualifications of volunteer nurse's aide instructors.

* Administrator, Steering Committee, Joint Board of Directors of the Three Maryland State Nursing Organizations.

5. Advise on the adequacy of classrooms and working equipment.

All teaching material for volunteer nurse's aides is prepared by the Red Cross nursing staff with the advice of national leaders in the medical and nursing professions.

1952 BIENNIAL NURSING CONVENTION

During the week of June 16–20 at their Biennial Convention a new structure of national nursing organizations was achieved. There is now a revised and expanded American Nurses' Association and a new National League for Nursing. The A. N. A. has nurse members only, while the N. L. N. has non-nurse and agency members as well as nurses. The purpose of the A. N. A. is to foster high standards of nurse practice and to promote the welfare of nurses through the coordinated action of organized professional nurses. The purpose of the N. L. N. is to foster the development and improvement of organized nursing services and of education for nursing, through the coordinated action of nurses, allied professional groups, general citizens, community agencies and schools, to fill nursing needs of people. Maryland nursing organizations are planning for similar reorganization on the state level.

Mrs. Elizabeth K. Porter, R.N., of Cleveland, Ohio, was reelected president of the A. N. A. and Miss Ruth Sleeper, R.N., of Boston, Massachusetts, was elected the first president of the new N. L. N. Of special interest to people in Maryland were the elections of Miss Miriam Robider of Baltimore as Chairman of the Private Duty Section of the A. N. A. and Mr. George W. Mason of Baltimore as a director of the N. L. N.

Student nurses in attendance at the Biennial Convention decided to create an independent nursing council. This will be formed under the sponsorship of the coordinating council of the A. N. A. and N. L. N. More than 1,000 students attended, approximately 50 of whom were from Maryland schools of nursing.

One of the most important actions at the convention took place when the nurses supported a draft of nurses if required during a national emergency. The A. N. A. House of Delegates approved, with only a few opposing votes, a resolution which authorized the Board of Directors of the A. N. A. to approve legislation, if introduced into Congress during a national emergency, which would enact a selective service for nurses.

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THE DOCTOR JULIUS FRIEDENWALD MEMORIAL LECTURE

ANNOUNCEMENT

The Doctor Julius Friedenwald Memorial Lecture will be given by

DR. WALTER C. ALVAREZ

Professorial Lecturer at the University of Illinois Formerly of the Mayo Clinic

on

Some Curious Digestive Syndromes and Their Causes

On Thursday, October 9th, 1952, 8:30 P.M.

At the University of Maryland, School of Medicine Chemical Hall—Main Building

Northeast Corner of Lombard and Greene Streets

As a fitting memorial to the late Doctor Julius Friedenwald, a lectureship was established at the School of Medicine of the University of Maryland. A Committee consisting of Dr. Maurice Feldman, Dr. Maurice Pincoffs, Dr. Walter Wise, Dr. Samuel Morrison and Dr. H. Boyd Wylie, Dean of the School of Medicine, ex-officio, was appointed by the University of Maryland to administer this yearly lectureship.

It was felt that the establishment of a yearly lectureship with the presentation of a gastrointestinal subject would be a lasting tribute to the late Dr. Julius Friedenwald. It was this specialty to which he devoted his life and to which he contributed so much. Dr. Friedenwald's ability as a doctor was recognized by all. He was a scientist, teacher, writer and a physician who not only loved but truly lived for his profession. He was an inspiration and guide to all who were fortunate enough to be associated with him. In addition to his professional attainments in Gastroenterology, Dr. Friedenwald endeared himself in the hearts of his colleagues and fellow citizens. In his memory, this yearly lecture is given at The University of Maryland, School of Medicine, where he served so faithfully as Professor of Gastroenterology.

The first lecture was given by Dr. George Eusterman of the Mayo Clinic in 1946; the second in 1947 by Dr. Walter L. Palmer of the University of Chicago; the third in 1948 by Dr. Frank H. Lahey, of the Lahey Clinic of Boston; the fourth in 1949 by Dr. Henry L. Bockus, University of Pennsylvania Graduate School of Medicine; the fifth in 1950 by Dr. Andrew C. Ivy, of the University of Illinois, Chicago; the sixth in 1951 by Dr. Albert F. R. Andresen, State University Medical Center, College of Medicine, New York. The seventh lecture will be given by Dr. Walter C. Alvarez, October 9, 1952.

Dr. Alvarez, formerly of the Mayo Clinic, is now Professorial Lecturer at the University of Illinois.

Dr. Alvarez has been an intensive research worker. His early interest in intestinal physiology led him to establish the gradient theory of the gastrointestinal tract, with all its implications in terms of tonicity and peristalsis. He published a treatise on "Mechanics of the Digestive Tract." Later his work on "Nervous Indigestion and Pain," appeared and was widely read. His most recent book, "The Neuroses," has been favorably reviewed. These books mark his interest and approach to the large field of psychiatry in gastroenterology.

He is a past president of the American Gastroenterological Association and a recipient of the Julius Friedenwald Medal. The latter is given to a member of this Society who has distinguished himself as a Gastroenterologist of the highest standing.

TAKE NOTE OF YOUR AUGUST JOURNAL!

J. Albert Chatard, M.D.

Just a few words of "congratulations" to the Editor and his Associates, and the office staff that produced the August number of the Journal, which contains part of the Transactions of the Annual Meeting, 1952. I feel this number alone will do more good than all the notices, talks and warnings that we have brought out for years.

The complete work and reports will now reach the whole membership and not the few who attend but may not listen or take in the work of the Faculty for each and every member. Approximately twenty-five hundred copies of the Journal have been mailed out to the membership. Of this number, some will lie unopened, or some, if removed from the envelope, will lie on the desk for some time before going into the scrap basket. Others will be looked at but not read or digested. Like the "Bible," the words will fall by the wayside and take no roots.

I hope the greater portion of the members will read and absorb the matter included and bring forth "good fruit" in their appreciation of what is done for "so many by so few."